

TIME TO ACT

HIV/AIDS in Asia



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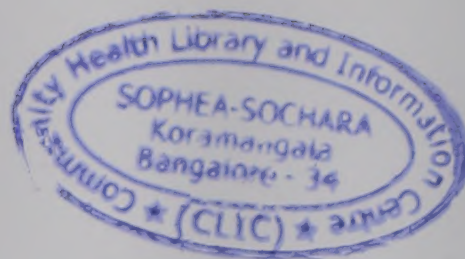
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FOREWORD

HIV/AIDS is wiping out a generation in Africa and a similar tragedy is beginning to unfold in Asia. Asia may not be Africa, but the early warning signals are scary and clear. Africa's experience shows HIV/AIDS can destroy development gains of several decades and social composition of peoples in a single stroke.

One of the key problems in combating HIV/AIDS, as this report notes, is the denial of its existence. This negative approach must change and policymakers may take tips from the 20th century writer Albert Camus, who said that perhaps the best way to deal with plague was by being honest about it.

Compassion and a humane response are necessary to deal with HIV/AIDS that has emerged as a public health challenge in Asia.

However, compassion cannot and should not be a substitute for governments' obligation to meet the challenge. Health care is not a matter of charity but a right. Recognising the needs and rights of people living with HIV/AIDS and ensuring health care and affordable medicine for them should be the priority. That is the best way to prevent a catastrophe.

HIV, like all disease-makers, is biased against the poor and the most vulnerable people. These are the same people whose voices are never heard, if not muffled. Political and government leaders need to understand that their interests should stretch beyond their vote banks, donors and sponsors. Responding to the needs of the most vulnerable sections of the society like migrants (who may never vote), children (who have yet to vote) and women (who seldom vote) is crucial. Political initiatives in some countries that this report highlights, such as the one in Timor-Leste (East Timor), offer hope – a clear road sign for others.

Bad policies breed greed. The last two decades have seen institutionalisation of a dubious dictum – profits at any cost. We hear the same slogan in different idioms that package it attractively as cost-recovery, user fee and market-friendly initiatives. Unpack it and you find the ugly face of anti-poor policies. This report urges financial institutions to draw a human face on their funding roadmaps and make sure they strengthen public health care systems.

It urges pharmaceutical 'giants' to place people before profits as an insurance against a grim scenario – 'medicine medicine everywhere, but not enough money to buy'. The report demands action to place patent rights of essential medicine, especially HIV/AIDS-related drugs in the public domain.

In short, HIV/AIDS is not just a medical issue. The issue of HIV/AIDS has socio-political, gender and cultural implications. There is a need to initiate organised action and concentrate public effort to fight the discrimination against people living with HIV. It is the poor, women and children who are at the receiving end of the stigma and discrimination. Changing this situation requires both societal action and public advocacy. It warrants a response from more than the health machinery and health industry. HIV/AIDS is a political issue, warranting a political response from governments and the corporate sector. The role of civil society and non-government organisations is crucial in making change happen on ground. ActionAid is committed to galvanise synergy and facilitate co-ordinated action.

We are also committed to listen and learn from our own experience in Africa and from others. This report, we hope, will serve as a 'reality check' for our future interventions in Asia. We are committed to respond in a variety of ways to the greatest public health challenge of our times. We see HIV/AIDS as an issue that warrants an emergency humanitarian response as well as a human rights and development intervention.

ActionAid Asia commits to place HIV/AIDS as a focus of our work to advance the rights of the most disadvantaged and vulnerable people, particularly their right to healthcare.

This report has drawn tremendous support from a wide range of actors working on HIV and AIDS in Asia. Special thanks goes to my colleagues, David Robinson and Professor Parasuraman of the Asia Regional Team who coordinated the report. We record our appreciation of the contributions of Christy Abraham, Max Martin, Prabodh Mani Devkota, Manvi Bista, Dr Mariette Correa, Reeya Chaicharas, Dr Joe Thomas, Meghna Girish, Shoba Ramachandran, Shailaja, Rajeevan, Gokul and Dr Unnikrishnan P V.

With space shrinking for the most disadvantaged and vulnerable people, we hope this report will help to amplify their voices. The upcoming International AIDS conference scheduled for July 2004 will be an occasion to use it effectively.

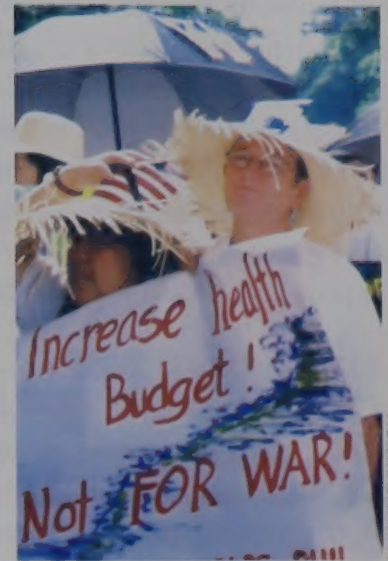
John Samuel

Asia Director

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Time is running out

HIV gains foothold, will destabilise societies, economies



The AIDS pandemic is one of the greatest humanitarian crises of all times. It has caused death and misery, destroyed families and communities and ravaged entire populations. Two decades after it began its onslaught in Sub-Saharan Africa, the disease has gained a firm foothold in Asia, threatening millions of lives in some of the world's most populous nations. "Over the next decade, without effective treatment and care, they will join the ranks of the more-than-20 million people who have died of AIDS since the first clinical evidence was reported in 1981," says a report by the United Nations Programme for HIV/AIDS (UNAIDS).¹

Snowballing crisis

Asia and the Pacific region have an estimated 7.2 million people now living with the virus, UNAIDS notes. Further 490, 000 people are estimated to have died of AIDS in the past year. Almost 1 million people in the Asia-Pacific region acquired HIV in 2002. About 2.1 million young people (aged 15-24) are living with HIV.

With the exception of Cambodia, Myanmar (Burma) and Thai-

land, national HIV prevalence levels remain comparatively low in most countries of Asia. Still there is no room for complacency. Both China and India, for example, are experiencing serious, localised, simultaneous epidemics that are affecting millions of people. In these two countries alone, at least five million people are believed to be infected with HIV, and epidemiologists forecast that the numbers will escalate rapidly, at a much faster rate than in Africa. It is the seriousness of the localised epidemics in several countries in Asia that make predictions for the spread in this region really terrifying. Concerns are also raised about a National Intelligence Council – an adviser to the CIA – report that stated by the end of this decade HIV infections may reach 25 million in India and 15 million in China. Experts suggest lower figures, but still involving millions.

Estimates are bleak and controversial. Given the grossly inadequate surveillance systems and the difficulties in estimating numbers, the prognosis regarding the extent of spread are educated guesses, to say the least.

HIV has gained a firm foothold in Asia, threatening millions of lives in some of the world's most populous nations

Surveillance systems at best reflect trends in a region and give snapshots of localised epidemics. What is certain though is that we are heading towards a crisis. With poor capacities to respond, it is just a matter of time before Asia, home to three-fifths of humanity on this planet, emerges as a mass graveyard.

It is time to do a 'reality check'.

A biased virus

HIV is said to know no boundaries and be blind to colour, creed, region and communities. Why then are some countries, some communities, some age groups and some populations more affected than others? The overwhelming burden of the epidemic today is borne by developing countries, where the disease threatens to reverse some important achievements in human development. AIDS and poverty have now become mutually reinforcing negative forces. Mostly, it is the

The epidemic in Asia threatens to become the largest in the world. With more than half the world's population, the region must treat AIDS as an issue of regional urgency. The question is no longer whether Asia will have a major epidemic, but rather how massive it will be... By not tackling it now while it is still manageable, the epidemic will have far-reaching effects, destabilising societies and damaging productivity.

– Dr Peter Piot, Executive Director of UNAIDS, at the World Economic Forum's (WEF) East Asia Economic Summit, October 2002

poor, dispossessed, the excluded and vulnerable groups that are most affected by HIV/AIDS. The processes of impoverisation also amplify vulnerabilities of the poor to the virus.

The virus thrives under certain conditions; some host populations are more welcoming than others. The reasons for this discrimination are complex and varied and include poverty, illiteracy, migration, trafficking, war and conflict, distress, violence against women, alcoholism, drug use and trafficking, lack of good governance, lack of political will, prostitution, low status of women and girls, powerlessness of marginalised groups, social disintegration, changing lifestyles and sexual habits. It is clear that the virus targets the poor. However, the ability to live with the infection and lead productive lives is a privilege of only the rich. The cost of HIV/AIDS drugs and care are far beyond what poor people can afford.

Socio-economic and political factors at the local and national levels continue to determine entitlements and opportunities for the infected and those vulnerable to infection. International financial institutions are undermining the ability of developing countries to invest in the social sector and effectively prevent and treat epidemics such as HIV/AIDS. They force governments to privatise and put a price on essential resources and services such as water supply, health care and education while wrenching open local markets to skewed international competition. Often poor people cannot pay, despite propaganda to the contrary. In the emerging global context, the poor, dispossessed and vulnerable groups face renewed exclusion from opportunities and access to services.

Women at risk

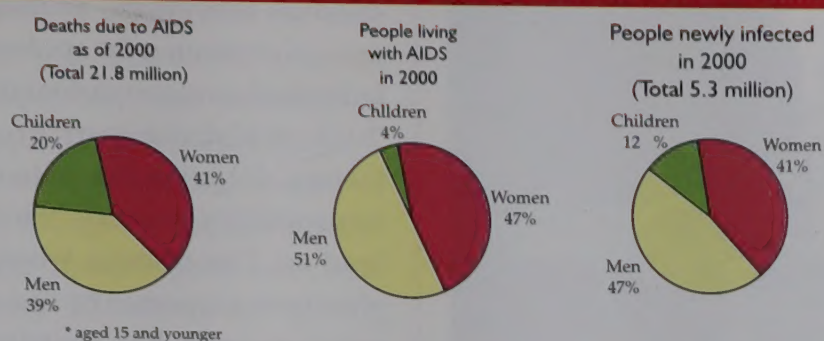
The fact that HIV/AIDS poses a greater threat to women and girls is now undisputed. In 1997, women represented 41 per cent of adults infected with HIV; by 2000 this figure had reached 47 per cent. It is also clearly evident that there is a direct correlation between increase in HIV prevalence and proportion of women infected with HIV.

HIV/AIDS is threatening to become a *weapon of mass destruction* aimed at the poor. For instance, forces that dispossessed and disempowered people in Southern Africa are again at work, leaving people to be destroyed by HIV/AIDS, thereby pushing poverty and land issues to the background. In Asia too, the *war against poverty* is becoming a *war against poor and vulnerable groups* – a process hastened by HIV/AIDS.

Given the increased susceptibility of HIV positive women to illnesses, their lack of access to care and support, it is not surprising to note that out of the 21.8 million people estimated to have died of AIDS by 2000, the number of women was more than that of men – 9 million women, 8.5 million men, 4.3 million children. Whereas a lot of HIV transmissions in Asia in the 1990s occurred through commercial sex, half the new HIV infections now appear to be occurring among the wives and sexual partners of men who were infected several years ago.

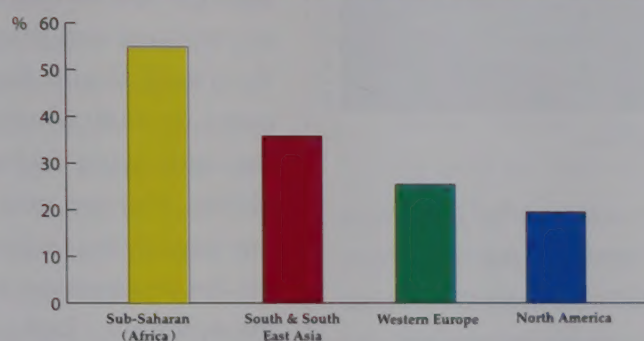
It is unfortunate that HIV/AIDS affects marginalised groups, further isolating them in the process. As the most common route of transmission is sexual, social mo-

The impact of HIV/AIDS on the world's women, men and children*



SOURCE: UNAIDS, AIDS Epidemic Update 2000, Geneva: UNAIDS, 2000

Proportion of women among HIV-infected adults



SOURCE: UNAIDS, AIDS Epidemic Update December 2000, Geneva: UNAIDS, 2000

rality prevents acceptance of those infected into the mainstream. Youth are particularly vulnerable. About 2.1 million young people, aged between 15 and 24, are living with HIV in Asia-Pacific, as the UNAIDS Fact Sheet 2002 notes. Of the world's 6.1 billion population in 2000, over a billion people, or 19.1 per cent, belonged to the age group of 10–19. The Asian and Pacific regions comprise 717 million people in this age group as the Fact Sheet notes.

Injecting drug use is another triggering factor. More than half the number of injecting drug users (IDUs) have already acquired the virus in parts of Malaysia, Myanmar (Burma), Nepal, Thailand and in Manipur state of India. Very high rates of needle-sharing have been documented among users in Bangladesh and Vietnam. Many street-based sex workers in Vietnam also inject drugs. In all countries of the region, HIV among those engaged in male-to-male sex features significantly in

the epidemic. Countries that measured HIV prevalence among men who have sex with men have found it to be rather high – 14 per cent in Cambodia. Male Thai sex workers also show the same infec-

tion level. Conflicts and mass movements of people in the Central Asia region and its fallouts have provided fertile grounds for the disease.

Vulnerability is further compounded by lack of access to information, education, health services and safe blood. A significant number of HIV transmissions take place through contaminated blood, a route that can be controlled to a large extent, mainly through state intervention. Still the fact that there are many blood banks in the region that are unregistered and thousands of people who still do not have access to safe blood and blood products reflects the importance given by governments to this route of transmission.

ActionAid (AA) recognises HIV/AIDS as a 'global development emergency', wiping out development gains and threatening the peace and stability of nations and sub-regions. AA also consid-

Collateral damage

Afghanistan's story is a case study that dramatically shows how war and conflict undermine people's health and bring about conditions in which HIV can thrive. The anarchic situation amid 24 years of war and local conflicts have set the scene for flourishing drug rackets, gun running, human trafficking and one of the world's largest refugee movements. Life expectancy in Afghanistan is perhaps one of the lowest in the world with UNICEF reporting that 165 out of 1000 children die before seeing their first birthday and 257 out of 1000 children before their fifth birthday.¹

Latest reports by the United Nations Office on Drugs and Crime (UNODC) indicate that the country has once again become a leading hub of opium trade.²

Life has been uncertain and unkind for the people in Afghanistan. HIV/AIDS is an added scourge for them.

1. UNICEF briefing on Afghanistan, <http://www.unicef.org/infobycountry/afghanistan.html>
2. Afghanistan Opium Survey for 2003, UNODC, UN Information Service, Press Release dated Oct 29th located at http://www.unodc.org/unodc/press_release_2003-10-29_1.html.



PALLAVA BAGLA ©

Poor hygiene in hospitals can lead to infections

ers HIV/AIDS as an emergency issue that calls for a humanitarian response. As an agency taking sides with the most vulnerable sections, ActionAid is committed to empower poor and marginalised communities by helping them gain control over the causes of their vulnerability, secure basic rights and needs, live with dignity and achieve sustainable development goals.

Fuzzy strategies

Ever since HIV/AIDS was first acknowledged as a problem, the strategies to address the issue have focussed on it as a disease, if not *the* disease. Despite the growing rhetoric in the recent years about HIV/AIDS being a development issue, there has been little attempt to convert this perception into meaningful strategies. Little has been done to address the root causes of vulnerability to infection. Large amounts of resources are invested into specific 'high priority' health problems, divesting, in the process, resources from a comprehensive approach that is sustainable and would benefit both HIV positive and negative people. There has

been little attempt to integrate HIV/AIDS into overall development initiatives, improve basic health services or strengthen the primary health care system.

The focus in Asia continues to be on prevention rather than treatment. People living with HIV/AIDS get little more than routine counselling and some treatment of opportunistic infections. Apart from concerns for the human rights of people infected with the virus, Asian countries will have to offer adequate care for over seven million people living with the virus in the next few years. The question is whether we have the facilities and political will to support this. The few community care centres that many Asian countries have are not enough. Health budgets are totally inadequate. And primary health care centres are not equipped to treat the repeated illnesses that these people suffer from. Governments should invest more in anti-retroviral (ARV) therapies, which will prolong people's lives. Placing the treatment for HIV and response for AIDS in the ambit of primary health care is perhaps the right way to begin. ARV can be made affordable.

Strategies tend to focus on individual behaviours, shifting the onus of containing the epidemic to individuals and people branded as 'high-risk' behaviour groups, thereby divesting the state of its responsibility to tackle the issue head-on. This strategy, which has often been supported by non-state actors as well, has contributed to further victimisation and stigmatisation of already marginalised groups such as homosexuals, sex workers and drug users. Even the *World Health Report 2002* focuses on individuals rather than the underlying factors of vulnerability. Hunger and poverty are key amplifying factors responsible for the progression and spread of the epidemic. Rather than focusing only on individuals and their 'behaviour', we need to change the larger social, economic and political systems that make these individuals vulnerable.

Root causes

The economic dimension of the HIV/AIDS scenario is often overlooked in discussions about its causative factors. The World Bank, one of the biggest 'donors' of the HIV/AIDS programmes worldwide, has also been responsible for structural adjustment programmes and a model of development based on the 'free' market system. These moves have only increased the gulf between the rich and the poor, inequity in health and diseases of poverty. When addressing the AIDS pandemic, the Bank conveniently ignores these underlying causes of poor health. Public health investment in India fell from 1.3 per cent of the gross domestic product (GDP) in 1990 to 0.9 per cent in 1999.² India's new health policy of 2002 recommends an increase to 2.0 per cent by 2010. However,

analysts in the People's Health Movement argue that the new policy is a 'sell out to forces of privatisation' and demands at least a 5.0 per cent allocation.

Poverty is not only a cause of HIV/AIDS spread but also a consequence. Limited gains from anti-poverty initiatives are getting washed off with HIV/AIDS. The World Health Organization (WHO) estimates that a nation can expect a decline in GDP of one per cent per year when more than 20 per cent of the adult population is infected with HIV. Studies quoted in a 2002 UNDP fact sheet note that rural families in Thailand show that farm output and income fell between 52 per cent and 67 per cent in families affected by AIDS. With the cost of medical care shooting up and governments surrendering health care to the private sector, medical expenses have become the leading factor of rural indebtedness in many Asian countries.

Because the disease grew so fast in the early years, death rates are going up. A recent study by the World Bank notes: "AIDS destroys human capital selectively, wrecking the health of the most productive members of the society."³

MILLENNIUM DEVELOPMENT
GOAL NO. 6: Combat HIV/
AIDS, malaria and other
diseases.

GOAL NO. 7: Halt and be-
gin to reverse the spread
of HIV/AIDS by 2015.¹

1. UNDP, Human Development
Report 2003, page 97

Money matters

In the developing world the number of people dying daily because of untreated HIV/AIDS has risen to 8,500, causing the WHO

to declare the lack of access to antiretroviral (ARV) therapy a 'Global health emergency'. Despite its emergency status, the resources generated to deal with HIV/AIDS are far from adequate. The Global Fund, the latest in a series of institutional mechanisms set up in January 2001 as a new multilateral emergency response to the grow-

Hunger and poverty are key amplifying factors responsible for the progression and spread of the epidemic. Rather than focusing only on individuals and their 'behaviour', we need to change the larger social, economic, political systems that make these individuals vulnerable.

ing pandemics of AIDS, TB, and malaria has been facing a serious funding shortfall.

Unless the Global Fund raises additional funds from the US and other donors, its well-publicised and WHO-promoted goal to provide therapy to 3 million people by 2005 will remain a distant dream. Only 2,40,000 people, or 8 per cent of the total number of patients, will be on ARV treatment by 2005, ac-

Approximately half of infectious disease mortality can be attributed to just three diseases – HIV, TB and malaria. These three diseases cause over 300 million illnesses and more than 5 million deaths each year.

cording to Global Fund officials. At the same time, many countries seem to be diverting funds from their existing aid budgets to meet their global fund commitments; making the amount of 'new' money committed to the fund far less than it seems. "Downsizing the scope and speed of the Global Fund makes sense if delegations want to shield themselves from criticism about their own stingy contributions," says Asia Russell of the Global Access Project. "But if you are one of the 3.2 million people living with HIV who will die without access to treatment next year, it makes no sense."

The Global Fund centralises the administration and takes planning and resources further away from communities. The emphasis of the Global Fund is on drugs, and it reinforces the approach of seeing HIV/AIDS as a medical mat-



People from various walks of life demonstrate in front of the US embassy in Manila, November 2003

Band-aid for the mind

Testing positive for HIV evokes severe psycho-social reactions in people. Once diagnosed, trauma takes its toll. Incidents of depression, anxiety, psychosis, acute adjustment reactions, and in some cases even attempted suicide have been reported. Good counselling services are designed to deal with this reality.

HIV/AIDS can trigger serious mental health problems. Apart from opportunistic bacterial and fungal infections, people living with HIV/AIDS (PLWHA) suffer from AIDS related dementia and other mental health syndromes characterised by confusion, intolerance, incoherent speech, decreased concentration, impaired judgement, and being unaware of the disease. Being sick and living an uncertain life under the shadow of death test the limits of human tolerance. A study of 226 destitute mentally ill people in institutional care in Chennai, India, revealed that 2.3 per cent of them were HIV positive.

The physiological and psychological problems PLWHA suffer from are further compounded by the social consequences of the disease. After testing positive for HIV, people have lost their spouses, their homes, their jobs, their property and, in a few cases, even their lives. Poor and other vulnerable sections suffer more. It is said that more people die due to the discrimination they face than as a result of any opportunistic infection.

"In fact, families, friends and employers can and should play a supportive role," says Dr Kishore Kumar K V, a psychiatrist working with the community mental health services programme of the National Institute of Mental Health and Neuro Sciences, Bangalore, India's premier mental health institute.

"Compassion, social support, access to health care and treatment are crucial in tackling the HIV issue."

ter rather than a social issue. Such approaches expose the fund to the criticism that drug companies and the World Bank have a disproportionate presence in their decision-making bodies, compared with representatives of people's groups and governments of developing countries.

The transparency of the entire process of accessing, managing and disbursing Global Fund money leaves much to be desired. Positive people's networks, community groups and non-government organisations (NGOs) have not been adequately involved in the country coordinating mechanisms. It appears that substantial Global Fund resources are diverted to the functioning of country offices of the WHO. Global Fund also has to take into account the local political and legal situations when financing programmes. The fund, for instance, has granted a sum of US\$1,000,000 for AIDS to an NGO of drug users in Thailand. But since February 2003, the Thai

government has been engaged in a brutal crackdown against people suspected of smuggling and dealing in drugs. There has to be some way to ensure the human rights of people dependent on drugs.

Bitter pills

While it is reiterated that AIDS is not a death sentence, seven million people in Asia will die well before their time if they are not immediately treated with life-saving drugs that are now available. We are talking about poor people who have very little access to health care, adequate nutrition, health insurance and are discriminated against in every sphere of their lives once their HIV status is known.

HIV/AIDS-related drugs are now a commodity for which a bitter battle is waged between western pharmaceutical giants backed by their governments against the poor people of the world. Stringent patent laws often make essential drugs beyond the reach of the poor. Drug prices add to the mounting

cost of the HIV/AIDS epidemic and changes in worldwide trade-related laws could improve the situation.

There was pressure on pharmaceutical companies and the US government to make some concessions at the fourth World Trade Organization (WTO) ministerial conference in Doha, Qatar (9-14 November, 2001). Despite having made a promise to uphold the rights of countries to protect public health and promote access to medicines for all, the developing nations are now trying to restrict the proposals in a manner that will effectively sabotage the process.

The basic issue relates to how countries in need of affordable essential generic medicines will get access to them. The 'compulsory licensing policy' which upholds the right of poor countries to manufacture patented drugs without consent of the patent holder has one major flaw - WTO rules require countries to produce and consume medicines domestically. Many countries are too small and

too poor to be able to do this, and therefore need to access the drugs from somewhere else. This is the key issue that is currently the focal point of the battle over AIDS-related drugs. Pharmaceutical companies in countries like India are now able to manufacture these drugs at a fraction of the costs at which their western counterparts produce them. But trade barriers prevent these affordable drugs from reaching other countries. Peoples and countries must retain the right to access drugs from sources most affordable. The patent for HIV/AIDS related drugs must be placed in the public domain, thereby enhancing capability of governments to serve people in a sustainable manner.

Related to this issue is another problem – even with the lower costs of manufacturers in the developing countries, many HIV-infected persons are still unable to afford them. It is here that governments of developing countries have an additional responsibility.

Rights and wrongs

One of the major stumbling blocks in the attempts to contain the HIV/AIDS epidemic has been the poor attention paid to aspects of human rights. While the connection between the two was recognised and acknowledged in the early stages of the epidemic, this is one area where very little has been achieved. That is, human rights are closely linked with the spread and impact of HIV/AIDS on individuals and communities around the world. On the one hand, a lack of respect for human rights fuels the spread and exacerbates the impact of the disease; on the other, HIV/AIDS undermines progress in the realisation of human rights. This link is obvi-

ous in the disproportionate incidence and spread of the disease among certain marginalised and oppressed groups, including women and children, and particularly the poorer sections of society. Human rights violations only add to the stigmatisation of persons at highest risk of infection and further marginalise and drive underground those who need information, preventive services, and treatment the most.

A wide range of human rights violations, including sexual vio-

sed – these are some of the issues within the human rights domain that need attention. In certain situations like prisons and remand homes, HIV spreads with great speed due to sexual abuse, lack of information and non-availability of condoms. Refugees, migrants and prisoners may also be more vulnerable to HIV because they often are unable to realise their civil, political, economic, social and cultural rights.

Inadequate legal frameworks to protect the rights of people liv-

The goal of realising human rights is fundamental to the global fight against AIDS. And in a world facing a terrible epidemic – one that has already spread further, faster and to more devastating effect than any other in human history - winning the fight against AIDS is a precondition for achieving rights worth enjoying.

– Dr Peter Piot, Executive Director, UNAIDS, Speech to the 59th Session of the United Nations Commission on Human Rights, Geneva, 19 March 2003



"Divert military expenditure for health care," health movements demand

lence and coercion faced by women and girls, exacerbates the disease spread. Women often lack voice in matters of marriage and child-bearing, men who have sex with men are often discriminated against, sex workers are abused, injecting drug users are harass-

ing with HIV/AIDS only aggravate the violations they are subjected to. In India, for example, an antiquated sodomy law contributes to police abuse of men who have sex with men as well as HIV/AIDS educators who work with these groups.

Interview with Dr Peter Piot, Executive Director of UNAIDS

Epidemic in Asia threatens to become world's largest

What do the trends in HIV/AIDS in Asia indicate?

HIV/AIDS is the most serious challenge to development that countries in the Asia-Pacific region have ever faced. In the Asia-Pacific region, which is home to more than half the world's population, seven million infections already have been recorded, with one million new infections last year.

The epidemic in South Asia is dominated by India, with the second largest number of HIV cases in the world. China's low national HIV prevalence rate obscures the concentrated epidemics in certain provinces where the epidemic has spread quite significantly in recent years.

HIV epidemics in Asia and the Pacific are diverse, localised and have different trends over time. Representing half of the world's population, the Asia-Pacific region has the potential to influence greatly the course and overall impact of the global HIV/AIDS pandemic.

The analysis of geographic differentials highlights the increasing severity of the epidemic and the potential for HIV to spread rapidly among high risk behaviour groups. In several countries it is alarming to see the spread of HIV from high risk behaviour groups to the general population.

HIV/AIDS is a real challenge for all countries in Asia, industrial or developing, rich or poor. It may threaten Asia-Pacific's prospects for continued economic and social development, if countries and the international community do not act.

Is the world spending enough resources to combat HIV/AIDS in Asia?

Currently a large proportion of the world resources are being spent in Sub-Saharan Africa.

This is predominantly so as the bulk of the epidemic is manifest in these countries. On a broad scale, approximately 20 per cent of the globally available world resources are being spent in the Asia region. However this should not undermine the additional resources that are being mobilised within the region in terms of the technical, human and financial resources. Major global initiatives are increasingly funding prevention activities in Asia.

Where does Asia figure in the UNAIDS response to HIV/AIDS?

Needless to say, Asia is high on the UNAIDS list of priority regions. With almost seven million people infected with HIV, Asia is the largest group outside sub-Saharan Africa. As I have mentioned before, the epidemic in Asia threatens to become the largest in the world. With more than half the world's population, the region must treat AIDS as an issue of regional urgency. The question is no longer whether Asia will have a major epidemic, but rather how massive

it will be. Of particular concern are China and India that alone have a population in excess of 2.2 billion.

How do you rate government responses in Asia region?

The response to the epidemic in Asia is a mixed one. While some countries in the region have shown the will to take on the epidemic head on, many of the countries still are going through a phase of denial. It is important that these countries recognise that by delaying the response not only will the window of opportunity narrow but also add to the burden of increased numbers and cost – both physical and economic – which countries can ill afford.



Any additional issues relevant for Asia region?

Leadership at all fronts is the key to the further prevention and spread of the epidemic in Asia. Political leadership is a vital tool in turning back the epidemic. Elected representatives and other decision-makers need to come together and dedicate themselves to the common cause of fighting AIDS. Political leaders have a key role to play in reversing the spread of the epidemic. In making laws, mobilising resources and determining policy choices, government leaders have the power to effectively fight the epidemic.

People living with HIV/AIDS are subject to stigmatisation and discrimination in all spheres of life. They face it in the workplace and while trying to access jobs. Fundamental human rights of people living with HIV/AIDS are denied. Their right to non-discrimination, equal protection and equality before the law, privacy, liberty of movement, work, equal access to education, housing, health care, social security, assistance and welfare, are often violated. "While there has been a consensus amongst the specialists in the field of public health to recommend education and prevention, the legislators tend to prefer a policy of testing, criminalisation and deportation of HIV-positive people. There is often a 'policy of separation and segregation of people with HIV and AIDS'.⁴

Women are particularly affected; once their husbands die of AIDS they are rejected by their husband's families, denied property and left with practically no resources to fend for themselves. Children who have lost parents to AIDS or who themselves are living with the virus, have lost their inheritance rights, are shunned by relatives, refused admission in

schools, forced into hazardous labour including prostitution, and are often compelled to live on the streets where they are subject to police harassment and other

Life-term freedom

Indian government is being challenged in the country's Supreme Court in a public interest petition that alleges poor people with HIV who require hospital care and drugs are given no treatment 'in any public hospital' and are 'simply left to die'. The petitioners are seeking court direction from the government to provide free and equitable access to ARVs, review public policy, create the necessary health infrastructure and declare a national emergency and invoke the compulsory licensing provisions of the Trade-Related Intellectual Property Rights (TRIPS) Agreement, so that treatment can be provided using generic drugs.

There is also the need in the region to rapidly improve the capacity of the countries to efficiently and effectively channel the resources that are already available and also new resources that are being mobilised. There is need to build capacities on all fronts to confront and control the epidemic. Of particular concern for this region are the ever-increasing numbers of injecting drug users and cross-border migration and trafficking issues.

abuses. HIV/AIDS is increasingly becoming a cause of orphanhood and destitution among young people.

Lack of respect for human rights increases vulnerability to HIV infection of individuals and society at large. Individuals or groups who suffer discrimination and lack of human rights protection are both more vulnerable to becoming infected and less able to cope with the burdens of HIV/AIDS.

The response to the HIV epidemic is further hindered due to lack of enjoyment of freedom of speech and association in some countries in Asia; the right to information and education by infected and affected groups, and civil society at large.

Merely making the right noise

Despite the bleak scenario, Asia may still be able to slow down and even stop the spread of HIV. But this calls for a paradigm shift – of response strategies, political commitment and resource allocation. Asia does not figure as a priority area by the international community for now. In the United Nations special one-day session on AIDS in September 2003, no Asian head of

state spoke. Despite the commitment of many Asian leaders to join the Bush administration's 'War on Terror', the US has overlooked Asia in its proposed \$15 billion allocation to fight AIDS. The Bush administration, by the way, is currently spending more than US\$ 4 billion per month for the military exercises in Iraq.⁵

It is still possible for developing countries to invest enough resources to overcome poverty, illiteracy, poor health and HIV/AIDS. But its scarce resources are diverted to debt repayment, misplaced development projects, and conflicts – internal and external. Civil wars are often triggered off by grave social, economic and political injustices. It is time that scarce resources are used to secure and honour rights of people to health, education and security.

There is very little accountability on the part of the governments to fulfil their commitment to ensure health for all, envisioned in the Alma Ata declaration 25 years ago. Lack of skilled personnel and training institutions and dwindling resources make the basic health care situation rather poor while elitist super-speciality centres flourish in a few pockets. This paradigm shift first tried out in the western world of medicine is now spread globally as the World Bank determines the curricula through its funding to medical training institutions. There is a failure to decentralise resources and develop local capacities.

The lack of political commitment is reflected in the fact that the AIDS pandemic continues to ravage populations in developing nations. There have been innumerable declarations of commitment over the years – the Millennium Development Goals, the United Nations General Assembly Special

Positive moves

Uganda has succeeded in controlling the HIV epidemic over the past 15 years. Changes brought about in the age of sexual debut, casual and commercial sex trends, partner reduction and condom use appear to have played key roles in the decline. Most importantly, Uganda's President Yoweri Museveni responded to the emerging epidemic with a proactive commitment to prevention, emphasising that fighting AIDS was a patriotic duty requiring openness, communication and strong leadership at all levels. His directness in addressing the threat placed HIV/AIDS on the development agenda and fostered a multi-sectoral response with overwhelming support at all levels.

Brazil's experiment of providing Highly Aggressive Anti Retroviral Therapy (HAART) to all HIV/AIDS patients has resulted in the country holding down the rate of new infections at the 1995 level. "We've put our case to the world and we've fought for it. And what is our case? It is that access to medicine is a basic human right. Now the Brazil story is a model for other developing countries," says Jos Serra, health minister of Brazil.

Session on HIV/AIDS (UNGASS), the Declaration of Commitment on HIV/AIDS (June 2001), the Human Rights declarations, the UN commitment to provide three million people with ARV by 2005 – the list is long.

The importance of accountability was acknowledged for the first time in the UNGASS Declaration on HIV/AIDS. It even called for strengthening of national monitoring mechanisms for HIV/AIDS related human rights. But the question is whether these systems have been put in place by governments.

Recommendations Be inclusive

There is a need to respond to HIV and AIDS in a **holistic way** and to integrate the response into the public health care system. For this it is important to strengthen the primary health care system while improving HIV/AIDS pre-

vention and care initiatives by generously allocating more resources. Diverting one-fourth of the military expenditure for public health in the next ten years is a must. Mass-scale infections like HIV pose a potential security threat and the biggest budgets anyway go for military and security purposes. Inclusiveness could also be enhanced by mainstreaming the health and HIV/AIDS agenda into the global justice movement.

Be responsible

Governments must take responsibility and recognise **health as a right** and make adequate provisions to ensure that right in constitutions, and legal frameworks, and in their implementation. Ensure that no force is allowed to weaken the capacity of governments to discharge their obligation to their people. There is a window of opportunity in new de-

mocracies like Timor-Leste (East Timor) and countries being rebuilt like Afghanistan to take up such issues more systematically and creatively.

While the struggle for social and economic justice must be intensified, the state, market forces and global multilateral and bilateral institutions must be held responsible for the suffering, death and destruction inflicted on the poor and vulnerable groups by HIV/AIDS and other diseases. Peoples' groups, networks and movements working to achieve social and economic justice for all must address HIV/AIDS in a most concerted manner to reverse the trend.

Be humane

Governments must also ensure coordination between various players like the corporate sector and commercial establishments, especially in the field of medical care and drug manufacturing. Pharma companies must place **people before profits**. Governments must ensure that patent laws on HIV/AIDS medicine do not constrain their capacity to honour rights of their people to treatment. Ensure that patents on HIV/AIDS drugs are located in the public domain, providing unhindered access to people.

The Global Fund needs to be more sensitive. The medicine purchased out of the Global Fund must be generic. The Fund should reject 'drug donation' outright as studies have proven that 'donation' does not help recipients, but big companies. Representatives of people living with HIV/AIDS and networks should have their rightful space in the decision-making body of the Fund.

Be synergic

Governments must make innovative exercises to **ensure synergy** and coordination between pillars of democracy – judiciary, legislature and media. Legislators have to give more voice to people living with HIV/AIDS. Judiciary must ensure a more humane legal system and play an active role to educate people about their rights and how to secure them.

Endnotes

- 1. UNAIDS briefing note
- 2. Government of India, The New Health Policy original doc, located at <http://mohfw.nic.in/np2002.-htm>
- 3. World Bank study quoted by Asia Times Online Co. Ltd, Hong Kong
- 4. Bloom, L (1991), *AIDS and Moral Theory: An Inadequate Response from the World Community*. *International Law and Politics*, Vol. 23, 1034, 1991
- 5. Iraq Effort to Cost Tens of Billions, Washington Post, August 27, 2003

References

Addressing Chronic Conditions in Primary Health Care, Ministry of Health and Medical Education, Islamic Republic of Iran, World Health Organisation, 2001

www.unaids.org/en/resources/epidemiology.asp

China's Epidemic of Secrecy, Joanne Csete, National Post, October 30, 2003

People's Charter for Health, People's Health Movement

Ravaging the Vulnerable: Abuses Against Persons at High Risk of HIV Infection in

Bangladesh, Human Rights Watch, Vol. 15, No. 6(C), August, 2003

Success Hinges on Respect for Rights in Drug Crackdown, Human Rights Watch, New York, October 31, 2003

WTO Summit: Don't Undercut AIDS Drug Access, Human Rights Watch, New York, November 7, 2001

UNAIDS epidemic update, December 2001

<http://www.rediff.com/news/2003/aug/04aids.htm>

<http://bmj.com/cgi/content/full/327/7411/360-c>

HIV Treatment Bulletin Vol 4 No 8 October 2003

Activists: Global Fund for AIDS Shrinking By the Day, Health GAP (Global Access Project), Chiang Mai, Thailand, October 16, 2003

<http://southasia.oneworld.net/article>

www.healthgap.org

AIDS in Asia TIME Asia, September 30, 2002 / Vol. 160 No. 12

Press Release, UNAIDS, October 7, 2002, Kuala Lumpur

www.unaids.org

www.unaids.org/partnership/index.html

UN Official Warns Asia Could Face World's Worst AIDS Crisis, Associated Press 10.07.02;

www.cptech.org/ip/wto/p6/

<http://www.accessmed-msf.org/>

www.aegis.com

www.thebody.com

www.massiveeffort.org/html

www.hivinsite.ucsf.edu

AIDS IN ASIA: The Continent's Growing Crisis- AIDS menace bears down on Asia, Sabin Russell, *San Francisco Chronicle* November 17, 2002

The question is no longer whether Asia will have a major epidemic, but rather how massive it will be. Of particular concern are China and India that alone have a population in excess of 2.2 billion.

ESTIMATED NUMBER OF PEOPLE WITH HIV/AIDS IN ASIA

Asia and the Pacific Islands are home to more people living with HIV/AIDS than any other region besides sub-Saharan Africa. UNAIDS says these figures are minimum estimates at the end of 2001. The virus is spreading mainly through unprotected sex, drug use and unsafe blood donation procedures.

East Asia and Pacific

	Total	Women	Children	Deaths
China	850,000	220,000	2,000	30,000
North Korea	NA	NA	NA	NA
Fiji	300	<100	NA	NA
Hong Kong	2,600	660	<100	<100
Japan	12,000	6,600	110	430
Mongolia	<100	NA	NA	NA
Papua New Guinea	17,000	4,100	500	880
South Korea	4,000	960	<100	220
Totals	886,000	232,420	2,810	31,630

South and South-East Asia

	Total	Women	Children	Deaths
Bangladesh	13,000	3,100	310	650
Bhutan	<100	NA	NA	NA
Brunei Darussalam	NA	NA	NA	NA
Cambodia	170,000	74,000	12,000	12,000
India	3,970,000	1,500,000	170,000	NA
Indonesia	120,000	27,000	1,300	4,600
Laos	1,400	350	<100	<150
Malaysia	42,000	11,000	770	2,500
Maldives	<100	NA	NA	NA
Burma	NA	NA	NA	NA
Nepal	58,000	14,000	1,500	2,400
Pakistan	78,000	16,000	2,200	4,500
Philippines	9,400	2,500	<10	720
Singapore	3,400	860	<100	140
Sri Lanka	4,800	1,400	<100	250
Thailand	670,000	220,000	21,000	55,000
Vietnam	130,000	35,000	2,500	6,600
Totals	5,270,200	1,905,210	211,890	89,510

Source: UNAIDS
NA=Not Available

Alarm bells

Poverty stokes HIV flames across borders



South Asia, with Gross National Income (GNI) per capita at \$460, is home to nearly half of the world's poor people living on less than \$1 a day.¹ Since 1990 the region has experienced rapid GDP growth, averaging 5.5 per cent a year, which has helped to reduce the consumption poverty rate substantially. India, the largest country in the region, has reduced poverty rate by 5–10 per cent since 1990; most other countries also registered a significant reduction in poverty over the period, except Pakistan where poverty has stagnated at around 33 per cent.²

Looking at other indicators of social progress, the region has had encouraging success in some areas. For example, mortality in children under five has reduced substantially (from 129 to 99, per 1,000) since 1990, especially in Bangladesh (144 to 77, per 1,000) and appreciable gains have been achieved in total school enrolments and completion rates. At the same time, challenges remain in key areas such as child malnutrition, maternal mortality, and health outcomes – nearly half of all children under the age of five are malnourished and youth illiteracy is high.

The poor nutritional status of mothers in South Asia manifests in the alarming rate of babies born with low birth weight. In addition,

gender remains a major determinant of adult literacy with illiterate women numbering 25 per cent more than men in South Asia.³ However, there are exceptions. Sri Lanka has a high literacy rate – 93 per cent for men and 87 per cent for women. Women's position is strong in Bhutan, particularly at the household level.

Infectious diseases like malaria, tuberculosis (TB) and respiratory illnesses have been a major cause of death and disability in the region. The resurgence of tuberculosis, the threat of HIV/AIDS and the AIDS–TB nexus pose a major concern. WHO's *World Health Report – 2003* states that in Pakistan, 171 out of 100,000 persons get tuberculosis every year. Each year, at least 268,000 new TB cases are added to the current number of around 1.8 million. Tuberculosis kills 64,000 people in Pakistan each year, a little more than a quarter of avoidable deaths. Most patients are in their prime productive age of 15 to 45, a little less than half of them women. Tuberculosis and malnutrition can rapidly reduce the life span of people with HIV/AIDS.

Rapid strides of a killer

First identified in the early 1980s, HIV/AIDS has spread rapidly in South Asia since the 1990s.

*South Asia
is emerging
as the
poorest, most
malnourished,
least gender
sensitive,
indeed most
deprived region
in the world*

By now it poses a major threat to development in India, Pakistan, Bangladesh, Nepal, Sri Lanka and Bhutan. South Asia accounted for about 4.2 million of the world's 36 million people living with HIV/AIDS by 2001.⁴ The raging epidemic is fuelled by poverty, illiteracy, gender inequality and social marginalisation. Migration, conflicts, disasters and displacement stoke it further.

Carol Bellamy, Executive Director of the UN International Children's Fund (UNICEF) has called for a quantum shift in efforts to confront HIV/AIDS in the region. Speaking at the Conference of South Asian leaders in Kathmandu in February 2003, she warned that the ingredients – ranging from poverty, illiteracy, gender inequities, trafficking and sexual exploitation of girls, high intravenous drug use, unsafe sex and denial of the seriousness of the problem – for an HIV/AIDS-driven catastrophe are amply present in South Asia. "The tipping point has been reached, and the window of opportunity to act is closing rapidly," she warned.

India, Nepal and Pakistan are classified by UNAIDS as moderate prevalence countries while Bangladesh, Sri Lanka and Bhutan are low prevalence countries. National HIV prevalence levels remain comparatively low in most countries but macro-level statistics can be a smokescreen. The region's large populations mean that even a small rise in the relatively low overall prevalence rates will translate into huge numbers of people living with HIV/AIDS. India's adult HIV prevalence rate, for instance, is currently less than one per cent according to the National AIDS Control Organisation (NACO), but in real numbers the

The tipping point has been reached, and the window of opportunity to act is closing rapidly

– Carol Bellamy, Executive Director, UNICEF

overall figure is the second highest in the world, after South Africa. NACO announced in July 2003 that there were 4.58 million HIV-positive people in India, a significant increase over the 3.97 million cases reported in 2001. The epidemic is spreading like wildfire.

NACO Project Director, Meenakshi Datta Ghosh reports that 61.5 per cent of HIV-positive Indians are men. "The disease is gradually spreading into rural areas and the general population," she said. Six out of the 30 states are listed as 'high prevalence' areas that harbour serious localised epidemics with prevalence rates many times higher than the national average. India's neighbour Nepal is fast turning from a low-prevalence to high-concentration epidemic area. The rate of infection is rising among vulnerable groups in Pakistan, Bangladesh and Sri Lanka even as Bhutan opens its doors to the outside world, HIV flames could also burn into the remote Himalayan kingdom.

Sick systems

There is already a high deficit of trained human resource and inadequate health infrastructure in the public health system in most countries. In Nepal and Bangladesh the ratio of population per doctor is 16,667 and 12,500 respectively.⁵ India's National Population Policy of 2000 estimated that the country's primary health care system was short of 23,190 sub-primary centres, 1,513 primary health centres and 2,899 community health centres. Thus, the crucial issue in countries with large popula-

tions and limited medical services is accessibility to health care.

Yet another increasing concern in the region is the issue of blood safety. In 1995, WHO Global Programme on AIDS (GPA) estimated that less than half the number of blood transfusions in the region were being routinely screened for HIV.⁶ In Bangladesh, India and Myanmar (Burma), screening of donor blood for HIV remains far from complete. Measures are being taken through improved donor selection to address this issue. In 1998 The Supreme Court of India banned buying blood from 'professional' donors.

There is widespread use of unsterilised needles in Pakistan and exposure to infected blood or blood products account for approximately 20 per cent of reported cases. Studies indicate that 94 per cent of injections are administered using re-used injection equipment. Infected blood and blood products account for almost one-fifth of reported HIV positive cases in Pakistan, according to a World Bank study.⁷ Branded anti-HIV drugs can cost patients \$500 to \$800 a year, a UNDP study notes.⁸

A grim scene

Poverty and development: In South Asia, earning losses in the context of HIV/AIDS are staggering. A UNDP study estimates that in Sri Lanka, lost lifetime earnings due to an AIDS death were 11 times the annual treatment cost.⁹ In Nepal, such losses are more than four times the per capita annual income. Inequalities, widespread poverty and lack of sustainable livelihoods have stoked the spread

There is an almost-hysterical kind of fear at all levels, starting from the humblest, the sweeper or the ward boy, up to the heads of departments, which makes them pathologically scared of having to deal with an HIV-positive patient.
A retired senior doctor from a public hospital in India

of HIV, further worsening the vulnerability of poor people. Economic and human poverty reduce the power of people to control their circumstances and negotiate choices. UNDP studies show that HIV/AIDS hits hard programmes aimed at poverty reduction, household food security, infant mortality reduction, better life expectancy and education.

Poverty and Trafficking: High levels of unemployment sometimes make many poor people choose sex work or drug peddling as a means of livelihood. More often, racketeers lure unemployed youth into these trades with false promises of a career. Annually, 5000 to 7000 Nepali girls are trafficked to India. More than 100,000 young girls and women from Nepal have been trafficked to Indian brothels, says an AA Nepal position paper.¹⁰ Over 100,000 women and girls are engaged in sex work in India's commercial hub, Mumbai, alone, a large number of them already infected, says World Bank's AIDS Regional Up-

Losing innocence

"Yes!!! I was trafficked into an Indian brothel and now I am HIV infected. Is it my fault? If a nine-year-old girl is compelled to live in hell, is it her mistake? Was it my wish to be a prostitute? This society and poverty has brought this situation on me. I know I am at my last stage of life and will soon die, but, I am determined to fight..."

– Batuli from Nepal at a National level Campaign, at Chitwan.

(Batuli died four months after this interview)

A man-made disaster

"My husband had many mistresses and made no bones about visiting them. He also fell ill often and a mysterious disease was eating him up... We were both HIV positive. After his death, I returned to my grandmother's house. Is a woman's life without any value? Why are girls never educated and always taught to accept?"

– Jhuma, Bhoruka Public Welfare Trust, Kolkata.

date, 2003. About 100,000 injecting drug users in Pakistan are at risk, and 41 per cent of people with HIV/AIDS in Bangladesh have been migrant workers.

Low status of women: Nearly 36 per cent of all people living with HIV/AIDS in South and South-East Asia are women. The low socio-economic status of women in many countries in these regions often leaves them with little choice in the matter of safe sex. In South Asia with an average literacy rate of 56.3, only 41 per cent of women are literate. In Nepal and Pakistan the figures are still lower. Social and religious sanction to polygamy in some sections of the community adds to the vulnerability of women. Abuse and violence against women and lopsided marital and property laws increase their vulnerability. A World Bank study in India claims that 90 per cent of HIV infected women were married and had sex with only one partner – the husband.¹¹

Abortions are considered illegal in Sri Lanka, Bangladesh and Pakistan, depriving women of physical well-being and health. Child marriage is rampant in the region. Apart from their vulner-

ability to infection, the women often have to share a disproportionately high burden of earning livelihood, caring for the sick and suffering from alienation and stigmatisation for their own infection and others infection.

Traditions: Traditions often create barriers against 'safe sex' practices and open discussion on sex and sexuality. A study in Bangladesh showed that the use of condoms among 36,000 commercial sex workers varied from 4 to 28 per cent.¹² Many 'untouchable' communities in India and Nepal are forced into sex work by tradition. About 40 per cent of Badi household in Nepal have at least one woman engaging in the sex trade.¹³

Drug abuse: South Asia is criss-crossed with drug trafficking routes – 'Golden Crescent' (Pakistan–Afghanistan–Iran borders) and 'Golden triangle' [Myanmar (Burma)–Laos–Thailand borders]. In fact, the North-Eastern region of India is considered the epicentre for HIV/AIDS infection through injecting drug use, with Manipur being the worst affected.

Armed conflicts: Conflict has become a crucial development

The disease is no longer affecting only high-risk groups or city populations, as it is gradually spreading into rural areas and the general population

– Meenakshi Datta Ghosh, project director, National AIDS Control Organisation (NACO), India

concern in South Asia. "When times are hard, the sense of injustice is often borne along ethnic, religious and caste lines. Violence thrives in poor societies where politics is weakly institutionalised, law and order is fragile and when the parallel economy is strong," as UNDP *Human Development Report 2003* notes. Territorial tensions and Internal security concerns have led to huge military spending by governments in Pakistan, Sri Lanka, India and Nepal.

Progress in India, Pakistan, Sri Lanka and Nepal has been slowed down by militancy and confrontation. Arms trade and money laundering form a vicious cycle of violence and poverty. Defence expenditure as a percentage of central government expenditure in Sri Lanka, Pakistan and India stood at a whopping 30.3 per cent, 21 per cent and 9.5 per cent respectively in 1991, according to UNDP. Pakistan spent US\$2,820 million as defence expenditure in 1999.¹⁴ However, the underlying causes of conflicts have seldom been seriously addressed.

Disasters and displacement: The region is prone to natural disasters like floods, famine, drought and earthquakes. Communal riots and separatist movements have caused large-scale displacement. There are an estimated one million Afghan refugees on Pakistan's borders and 96,000 Bhutanese in Nepal at risk of the infection.¹⁵

Responding to an emerging crisis

Most South Asian countries have established National AIDS policies and coordinating bodies through their health ministries, with support from the WHO, UNAIDS, World Bank, UN agencies and other multilateral organisations.¹⁶ The national poli-



AIDS and TB, a lethal combination

cies have focused on prevention through monitoring and surveillance, blood screening, awareness building and condom promotion. However, there is undue focus on 'target' populations like commercial sex workers, truck drivers and injecting drug users that are considered 'high-risk groups' more likely to contract and spread the infection. Governments have yet to take responsibility to protect the privacy of people with HIV/AIDS, legislate to protect their rights and allocate enough funds for their treatment and care. The stress is on the medical aspects of HIV/AIDS, overshadowing its socio-economic causes and consequences.

Bangladesh: After the epidemic became an issue during the early 1980s, Bangladesh Government formed a National AIDS Committee in 1985. The Bangladesh AIDS Prevention and Control Programme (BAPCP) of the Health and Family Welfare Ministry implemented a strategic plan from 1997 till 2002. With 13,000 people living with HIV/AIDS by 2000, returning nationals, commercial sex workers and clients and IDUs are considered to be more vulnerable in the country.

Bhutan: The National STD/AIDS Control Programme in Bhutan started in 1988, adopting a multi-sectoral initiative. More than 25 per cent of the government's total budget is allocated to the social sector. Currently less than 100 people are estimated to be living with HIV/AIDS.

Nepal: Nepal's AIDS Prevention and Control Programme (NAPCP) was established in 1987 under the Health Ministry. The National Strategic Plan of 1997 clearly indicates the government's commitment for a multi-sectoral approach in the fight against HIV. A 2002 estimate puts the number of people with HIV at 58,000 and infection is fast spreading into the general population.

India: India responded quickly to the epidemic after the first case was reported in 1986. NACO was initiated in 1987, and it is in its second phase currently. NACO formulates policy and implements prevention and control programmes. The National AIDS Control Board, chaired by the Health Secretary of the federal government, helps implement the state programmes. There are AIDS cells in states and union territories.

Though we do not have a policy so far, I can say that if at the time of recruitment there is a person with HIV, I will not take him. I'll certainly not buy a problem for the company
Human resources department head of a private company in India

India's Ministry of Health & Family Welfare has promulgated the National Health Policy (NHP) after a gap of 18 years, ever since the first attempt was made in 1983. The goals for 2000–2015 include zero level growth of HIV/AIDS by 2007, halving the number of deaths from TB, malaria and other vector and waterborne diseases by 2010 and reduction in child and mother mortality rates.

Pakistan: Pakistan's federal health ministry has initiated the National AIDS Prevention and Control Programme (NACP) in 1987. In 2001 the ministry has developed a strategic framework to guide the activities of the HIV/AIDS stakeholders. Provincial implementation units for AIDS control and safe blood use have been established in four provinces and two federally administered areas. 39 countrywide surveillance and diagnosis centres have also been established. There are an estimated 78,000 people with HIV/AIDS in Pakistan and injecting drug use is considered a key transmission route.

Sri Lanka: The National coordinating body is the National AIDS Committee (NAC). The HIV programme located within the health ministry focuses on prevention of sexually transmitted diseases and awareness creation among youth. Sri Lanka has an estimated 4800 people living with HIV/AIDS.

NGO Activities: A number of highly committed NGOs in the

In every family there is a high possibility of being engaged in traditional profession of selling sex

– Badi community member, Nepal.

Action against AIDS

ActionAid (AA) Bangladesh initiated its HIV/AIDS programme in 1995, becoming the first country programme of its kind within the AA network in Asia. AA addresses HIV/AIDS from a development perspective and dovetails it with family planning/ mother and child health programmes, savings and credit schemes and primary health care and health education initiatives.

AA Bangladesh facilitated a grassroots exhibition tour of 'Positive Lives Asia' for a period of twelve months. In Dhaka the learning was shared with policymakers, medical practitioners, and members of donor groups to help reduce the risk of HIV/AIDS spread in the country.

In 1998, AA India initiated its HIV/AIDS programme, focusing on sensitisation of communities, capacity building and working with groups of infected people. The initiatives include Manipur Network of Positive people, Enjoy, a network of positive people in Kolkatta and Milana, a newly formed infected women's network in Bangalore, Karnataka. Fellowships are provided to infected people to promote positive living. 'Positive Lives', and AA facilitated seminar-cum-exhibition was held in Kolkatta.

AA Nepal established *Makawan Pur Mahila Samuha*, a newly established organisation for women affected/infected by HIV/AIDS and trafficked women returning from Mumbai. This is the first organisation of its kind in Nepal.

AA's focus is to look at the epidemic from a human angle and to influence policymakers to mainstream responses to reducing poverty, gender inequality and favour human development programmes. AA recommends the following action points:

- *A protective law for marginalised groups facing discrimination*
- *Urgent attention on women and children who need HIV/AIDS care and protection*
- *Community Care and Social responsibility*
- *Listening to people with HIV/AIDS putting their rights in the centre of decision making*
- *Creating an enabling environment for safe behaviour*

countries of South Asia have initiated and implemented activities in various spheres of HIV/AIDS. Working with vulnerable people in urban and rural areas, they have been involved in all stages from prevention and control to care and support. Their work covers a broad spectrum of activities that include counselling services,

promotion of safe sexual practices, formation and support of self-help groups, networking with the government, hospitals and care centres and lobbying for better policies. Training and information on health and nutrition, care and positive living, promotion of de-addiction, recreation, and income generation



An AIDS hoarding at a government office, New Delhi

facilities are some other areas of NGO work.

Despite a number of humanitarian agencies working in the region, a lack of co-ordination be-

Medieval treatment

Munnuswamy Pavanamma was stoned to death by her relatives and neighbours on July 3, 2003 in Kuppam, India. Following the attack, neighbours burned Munnuswamy's body, the bench on which she was lying and a mango tree beneath which she had rested.

– WINS, an AA India supported project, took up the case and lodged complaints.

tween government agencies and NGOs has hampered efforts to rein in the worsening HIV/AIDS situation in most countries.

Issues of concern

Human rights violations: Rights of infected people to get educated, to marry, to work, to access health resources and to lead a life of dignity are often denied in many South Asian countries. Society discriminates out of sheer ignorance. And legal systems have failed to address this issue.

In the absence of any anti-discrimination legislation, courts sometimes uphold the rights of the citizens, drawing from national constitutions and international norms. Although the right to health is enshrined in many constitutions in the region, people with HIV/AIDS do face discrimi-

Abandoned youth

I am eighteen years old, but have been through hell. Trafficked at 14 for sex work, forced to abort twice and then separated from my newborn son. Rescued in a police raid, I am staying at a good home but have no family to return to. I often fall ill and am under treatment. I feel depressed to think about my future.

– Kavita, a girl with HIV, living in a care home in Mysore, India.

nation in health care settings by way of outright denial of treatment, isolation, early discharge, extra costs and prejudicial comments. Confidentiality about HIV status is often breached.

In Sri Lanka there has been at least one case of termination of employment on the basis of HIV status. In Bangladesh, there have been cases of people with HIV/AIDS being held in police custody.

The rapid pace at which the fire of HIV/AIDS is engulfing our societies is indeed alarming and it needs to be checked. We, the members of the South Asian Region have committed ourselves along with the global community to ensure that the spread of HIV is halted and reversed by 2015.

– Lokendra Bahadur Chand, Prime Minister, Nepal At SAARC conference on HIV/AIDS – February 2003

People view us with hatred and sympathy. We are ostracised by society and many even fear to touch us.

We are discriminated at all levels starting from the family

– Naresh Sreshta- President of Dharan Positive - a programme supported by AA Nepal

Business as usual

After the initial shock of knowing I was HIV positive, my wife and I decided to face the problem. I went back to work and was in for another shock – I was not allowed into the factory! The confidentiality of the tests done had been broken. I met a social worker who, in turn, contacted the National Law School University of India. Together, they convinced the management to get all the employees together for a counselling session. About 800 people attended, and once educated about the infection and precautions to be taken, they were ready to accept me back to work. Initially I had no job to do. Slowly, old friends came to talk to me. Finally, I was given the job of a receptionist. I don't keep too well but am lucky to have some friends.

– Ravi, member of *Milana*, a network of people with HIV, promoted by AA Bangalore

In India, a judgment of the Supreme Court of India (*Mr X v. Hospital Z*) suspended the right of people living with HIV/AIDS to marry. This had put forth a debate on the issue of fundamental rights and protection of the spouse and the court later revoked the order in 2002.

People with HIV/AIDS are systematically denied insurance. Though Bangladesh endorses the Universal Declaration of Human Rights, the government policy makes it mandatory for private and public health care institutions, employment clinics and the armed forces to notify the Director General Health Services about all people with HIV/AIDS in a 'confidential' manner. The recent trend in Pakistan of mandatory testing for IDUs is another violation of rights. A judgement from a High Court in India while upholding their right to education denied two infected siblings the right to study in a regular school.

Children at risk: Of the 1.8 million street children in Bangladesh, 20–30 per cent have had sexual experiences.¹⁷ Lack of access to homes, care and protection, education and information makes

them more vulnerable. In Nepal 15 per cent of domestic child labourers are victims of sexual abuse, says a report by Sancharika Samuha.¹⁸ Rates of HIV infection are rising among the youth in the age group of 15–24 years. Mother to child transmission accounts for about 90 per cent of HIV infection among children below 15 years of age in South Asia.¹⁹ The number of orphans due to HIV/AIDS-related death of parents is on the rise and care and support for orphans is a key issue.

Costly drugs: Four countries from South Asia, India, Nepal, Pakistan and Bangladesh submitted proposals that were approved by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in January 2003 with India getting the largest share of \$137,975,999. The Global Fund has approved a maximum grant of US\$19,961,030 for proposals

submitted by Bangladesh, US\$21,619,750 for Pakistan and US\$18,840,210 for Nepal over a period of five years, as on January 2003. Proposals from Bhutan and Sri Lanka did not receive funds from the second round. According to the World Bank, ongoing five-year-term HIV/AIDS projects supported by it have an outlay of US\$191million for India and US\$40 million for Bangladesh. Even with support from other UN and multilateral aid agencies, resource-strapped countries will find it difficult to make ARVs affordable to the poor unless pharmaceutical companies lower supply prices to developing



A public information campaign

nations. The Indian drug company Cipla has initiated such an effort, making its triple drug cocktail 'Triomune' available at cheap rates to people with HIV/AIDS. Now the Cipla combination is available at about \$32 per month.

Experience has shown that the best way to respond to this challenge is to act locally and collaborate globally.

– Atal Bihari Vajpayee, Prime Minister of India, at the Parliamentary Meet on HIV/AIDS, 2002.

The gender dynamics of the epidemic are far-reaching due to women's weaker ability to negotiate safe sex, and their generally lower social and economic status.

– Kofi Annan, UN Secretary General, July 2003.

Way forward

Dignity: Focussing on giving people a life of dignity by taking the stigma and discrimination out of HIV/AIDS would be a way forward.

Vaccines

Trial and error

Asia is becoming the new frontier of search for an anti-HIV vaccine. India is preparing to start phase-I clinical trials for an HIV vaccine developed by its National Institute of Cholera and Enteric Diseases (NICED), Kolkata, in collaboration with an US biotech firm.

The vaccine will be tried in 13 healthy volunteers in the age group of 18–50 in March 2004, as reported.

Trials elsewhere for an HIV vaccine is yielding no breakthrough. Latest media reports indicate the failure of vaccine trials in Thailand.

The trials involving MVA (Modified Vaccinia Ankara) HIV-1 subtype C would be conducted at the National AIDS Research Institute (NARI) Pune, under a tripartite agreement between the National AIDS Control Organisation (NACO), the Indian Council of Medical Research (ICMR) and the International AIDS Vaccine Initiative (IAVI), as reported.

The Phase-I would determine the safety, immunogenicity (ability to induce strong immune responses in the person to fight HIV) of the intramuscular vaccine, preliminary dose requirement and schedules for immunisation. This phase is expected to last two years.

The Indian Network of Positive People (INP+) says that the government has a social responsibility of providing easily accessible and affordable treatment options and accessibility to specialised and community based care. Similarly, there is a social responsibility of families and communities, media, donor communities and people living with HIV/AIDS themselves, in preventing the transmission of HIV and caring for people infected and affected. However, this task becomes difficult in a country like India with the majority of people living with HIV not knowing their status.

Legislation: Legislation and policy changes are also a step in the right direction. In India for example, a 1997 Mumbai High Court Judgment held that employers cannot base employment decisions on the HIV status of the employee.

Similarly, trade laws need to be relaxed to make drugs available and affordable to poor people. The Doha Declaration in Nov. 2001 reaffirmed that 'the TRIPS agreement does not and should not prevent members from taking measures to protect public health...' The Indian Patent Act has been amended in 2002 to protect domestic requirements. It can now by-

Participating in a media workshop in New Delhi in October second week, Indian officials expressed the confidence that the ethical and regulatory clearances on safety and toxicology and pre-clinical studies will be taken care of before March.

However, health activists are skeptical. Citing a long history of drug companies and governments not following ethical standards and strict scientific procedures in vaccine trials in this part of the world, the activists have raised serious issues.

"We have concerns about a vaccine jointly developed with a US firm being tried first in India," says Dr Amit Sengupta of the People's Health Movement. "There is a tendency to use countries like India for trials of pharmaceutical products developed in the north, making use of relatively lax regulatory mechanisms in developing countries."

Health activists acknowledge the need for a preventive vaccine, but argue that the need of the hour is a cure to the dreaded infection. On a broader plane, they demand a robust regulatory framework for clinical trials. They are concerned that ethical guidelines for vaccine trials in developing countries at present are operating in a regulatory vacuum.

Statistical Information

Table 1: HIV/AIDS in South Asia

Country	Estimated number of people with HIV/AIDS in 2002	Total Population (in Thousands)	Vulnerable Groups and Risk Factors
Bangladesh	13,000	140,369	Returning nationals, CSW and clients, IDUs, casual sex
Bhutan	<100	2,141	Returning nationals
India	3,970,000	1,025,096	CSW and clients, IDUs, casual sex, people with multiple partners and their spouses, blood transfusions and organ transplants
Nepal	58,000	23,593	IDUs, CSW and clients, casual sex, people with multiple partners and their spouses
Pakistan	78,000	144,971	IDUs, casual sex, people with multiple partners and their spouses, CSW
Sri Lanka	4,800	19,104	Returning nationals, foreigners, casual sex and people with multiple partners, CSW
(CSW: Commercial sex workers)			*UNAIDS, HIV/AIDS in Asia, 2002

Table 2: Government, Health Expenditure and Human Development Index

Country	Government	HDI Ranking (2003)	Health Expenditure- Public % GDP	Health Expenditure- Private % GDP	Population with access to Essential drugs (in %)
Bangladesh	Republic Parliamentary Democracy	139	1.5	2.6	50-79
Bhutan	Monarchy	136	3.7	0.4	80-94
India	Federal Republic	127	0.9	4.0	0-49
Nepal	Parliamentary Democracy	143	1.6	3.6	0-49
Pakistan	Parliamentary Democracy	144	0.9	3.2	50-79
Sri Lanka	Republic Parliamentary Democracy	99	1.8	1.9	95-100

Table 3: HIV Prevalence, Poverty Levels of Risk and Response

Country	HIV Rank	Adults (age 15-45) PLWHA in %	Human Poverty Index value	Population below National Poverty Line in %	Level of Risk	Level of Response
India	59	0.8	33.1	35	very high	high
Nepal	67	0.5	43.4	42	very high	low
Pakistan	95	0.1	41	34	high	low
Bangladesh	110	<0.1	42.4	35.6	high	medium
Sri Lanka	114	<0.1	17.6	25	high	low
Bhutan	131	<0.1	-	-	medium	medium

Countries are ranked by Adult HIV prevalence rate

* Adapted from UNAIDS 2002, UNDP Human Development Report 2002, World Bank Website

pass the World Trade Organization (WTO) restrictions under the Public Health clause.

Care for women and children:

There are efforts in the region to spread awareness by making sex

education part of the school curriculum. Youth in urban metropolitan cities in most countries have access to information and are beginning to discuss the issue. In its educational efforts, the region

still has a long way to go. Parents also need to be educated so that they feel comfortable to handle the issues with their children.

Media: The media plays a unique role within society either

to denounce or to perpetuate the bias and moral judgements against people with HIV/AIDS. Over the years, the articles have become more accurate, fair and probing the root causes of the issues. But the lack of new information on the scientific, sociological, developmental or human rights aspects of the epidemic still hinders the media coverage.

NGOs: NGOs and civil society organisations must take up HIV/AIDS issue as a campaign theme on a priority basis and should join coalitions and networks across the region. They should advocate for a Human Rights approach to HIV/AIDS and explore the connection between human development and HIV/AIDS issues.

There are localised multiple epidemics throughout South Asia. The epidemic may be still young in South Asia, but given the swifter rate of growth of HIV/AIDS, it is only a matter of time before multiple epidemics start to overlap. The time to act is now.

Endnotes

1. The World Bank Group, Millennium Development Goals – South Asia, Update 2003
2. The World Bank Group, Millennium Development Goals – South Asia, Update 2003
3. UNDP, HIV/AIDS and Development in South Asia, 2003
4. Mahbub-ul-Haq Human Development Centre, 2001
5. International Planned Parenthood Federation, Report located at <http://www.ippf.org/regions/southasia.html>
6. Status and trends of HIV/AIDS. Epidemics in Asia and the Pacific, Report dated 31st October, 1997 on

- IV International Conference on AIDS in Asia and the Pacific organised at Manila by AIDSCAP of FHI, FXB and UNAIDS; located at <http://cdpc.com>
7. World Bank Group, AIDS Regional Update 2003
8. UNDP, HIV/AIDS and Development in South Asia, 2003
9. *ibid*
10. ActionAid Nepal, A Position paper on HIV/AIDS, 2003
11. World Bank Group, AIDS Regional update, 2003
12. World Bank Group, AIDS Regional update, 2003

13. UNDP, HIV/AIDS and Development in South Asia, 2003
14. UNDP, HIV/AIDS and Development in South Asia, 2003
15. UNDP, HIV/AIDS and Development in South Asia, 2003
16. UNDP, HIV/AIDS and Development in South Asia, 2003
17. UNDP, HIV/AIDS and Development in South Asia, 2003
18. Sancharika, Samuha, Nepal, 2003
19. World Bank Group; AIDS Regional Update, 2003

References

ActionAid Asia (2003), *Asia Region HIV/AIDS Status Report*, April, 2003

ActionAid Asia (2003), *Asia Region HIV/AIDS Strategic Plan 2003-2005*.

ActionAid Bangladesh (2003), *HIV/AIDS Campaign of ActionAid Bangladesh*

Monitoring the AIDS Pandemic (MAP) (2001), *Status and Trends of HIV/AIDS/STI Epidemics in Asia and the Pacific*, October 2001

Narbikram Thapa; ActionAid Nepal (2002), *Sociology of People with HIV/AIDS in Nepal*

Sareendran Pallikadavath, R William Stones (2003), *Women's Reproductive Health Security and HIV/AIDS in India*, EPW Special Article Sept 27, 2003

UNAIDS/WHO (2002), *AIDS Epidemic Update*, December, 2002

UNDP (2002), *Policy Note on HIV/AIDS and Poverty Reduction Strategies*, August 2002

UNDP (2003), *HIV/AIDS and Development in South Asia – 2003*, Regional Human Development Report

United Nations (2003), *HIV/AIDS in the Asian and Pacific Region-Economic and Social Progress in Jeopardy*

On line references

Youandaids; UNDP's HIV/AIDS Portal for Asia, (<http://www.youandaids.org>)

National AIDS Control Organisation; India, (<http://www.naco.nic.in>)

International Planned Parenthood Federation, (<http://www.ippf.org/regions>)

Global Fund for AIDS, TB and Malaria, (<http://www.globalfundatm.org>)

Rajan Gupta, 2003; 'To Elicit the Required Response in India', (<http://t8web.lanl.gov/people/rajan/AIDS-india>)

Millennium Development Goals, South Asia (<http://www.developmentgoals.org/southasia>)

Silent spread

HIV threatens a region hit by shortages, trafficking

Tip of the iceberg

Central Asia's visible HIV/AIDS scenario is in all probability just the proverbial tip of the iceberg. As HIV continues to spread like a giant red blot of ink over the world, we are still largely unaware of the true impact it will have on the people, communities and nations affected in many parts of the world.¹ As HIV/AIDS becomes the most important public health threat, response to this epidemic is ravaging scarce resources and placing huge demands on already frail infrastructures, making it difficult for governments to deal with the problem.² The stark socio-economic background of many Central Asian countries makes the scenario even grimmer.

There is cause for serious concern in the region, despite comparatively lower numbers, as drug trafficking routes cut through here

By acting now and mobilising greater political commitment at the country level, governments and development partners could stave off major crises

and the health care system is still recovering from the collapse after the demise of the Soviet Union. Evidence from other regions suggests that drug trafficking, injecting drug use, and HIV infection are closely linked.³ Besides, Central Asian countries are showing rapid increases in the prevalence of STDs.⁴ Old estimates suggested rather smugly that the number of people living with the deadly virus in the five Central Asian countries was about 35,000, with 20,000 of them in Kazakhstan alone. According to a UNAIDS study, about one per cent of the population of the region was injecting drugs, and many of them were spreading the disease through unprotected sex. Studies also suggest that a vast majority of the infected are vulnerable youth, many of them drug users.

Experts now fear that the figures could be gross underestimates, given the poor surveillance system in many of these countries. A new estimate clustering Eastern Europe and Central Asia (ECA) together puts the figure far higher and notes that during 2002 alone a quarter of a million people were



There is cause for serious concern in the region, despite comparatively lower numbers, as drug trafficking routes cut through here and the health care system is still recovering from the collapse after the demise of the Soviet Union

infected in this region, making it a region with one of the fastest rates of HIV spread.⁵ While numbers of people documented as being infected with HIV are certainly growing, we do not yet have a clear idea of the true prevalence of HIV in the region. Case-finding surveillance is still used in Central Asia, testing those who are arrested for drug possession or otherwise 'registered' as drug users. In addition, there is a shortage of assays and adequate facilities to perform the tests. Central Asia also remains a mystery in terms of HIV subtypes. The region is surrounded on all sides by different subtypes.⁶ There is a crying need for better availability of drugs in Central Asia.

A World Bank strategy paper released on September 16, 2003, *Averting AIDS Crises in Eastern Europe and Central Asia*, argues that it is still possible to prevent the tremendous costs and social disruption that could result from generalised epidemics of HIV/AIDS in the region.⁷ "By acting now and mobilising greater political commitment at the country level, governments and development partners could stave off major crises," says Shigeo Katsu, the Bank's vice president for the Europe and Central Asia Region (ECA).⁸

Delegates at the 14th International AIDS Conference, in Barcelona, Spain, in 2002 have discussed how intravenous drug users were boosting the spread of HIV/AIDS in Central Asia. "In spite of the fact that Central Asian Republics (CAR) are now considered to be relatively low HIV prevalence countries, the rate of the spread of HIV is very high," says Alexander Kossukhin, programme officer for the joint United Nations

Programme for HIV/AIDS that is better known as UNAIDS. In 2001 the number of documented HIV cases in Kazakhstan and Uzbekistan increased three-fold in comparison with the year 2000.⁹ An UNAIDS report published in 2002 pointed out that the epidemic was growing in Kazakhstan. "Swift spread of HIV is now also evident in Azerbaijan, Georgia, Kyrgyzstan, Tajikistan and Uzbekistan," it noted.¹⁰

Experts say the situation is serious because besides drugs, there is a well-developed underground market for commercial sex in Kazakhstan, Kyrgyzstan, Uzbekistan and Tajikistan and sex workers and their clients tend not to practise safe sex. Evidence shows that where there are high rates of sexually transmitted diseases (STDs), HIV/AIDS follows. There is also a massive problem of education in the Central Asian region. "In some Central Asian Republics as of 2001, awareness of HIV/AIDS was still dismal among vulnerable groups, such as adolescent girls – a mere ten per cent of whom in Tajikistan had ever heard of

HIV/AIDS," the UNAIDS report said. "In 2001, in Azerbaijan and Uzbekistan, fewer than 60 per cent were aware of the disease," it added. Moreover, anonymous surveys carried out among various groups of population (especially rural) show insufficient knowledge about HIV/AIDS.

Failing health care, broken safety net

The Central Asian and other CIS countries have suffered the most serious reversals in living standards in the world during the course of the 1990s. There has consequently been a sharp increase in poverty. The fall in GDP has been accompanied by a growing incapacity of governments throughout the region to collect revenues. Real allocations to the social sectors have declined sharply. The total expenditure on health in Central Asia region in 1994/95 has been 37.7 per cent lower than in 1990/91.¹¹

Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, like the other constituent republics of the former Soviet Union, acquired political independence at the end of 1991 as a result



Health workers from civil hospital, Mazar-i-Sharif, Afghanistan

Facing the growing costs of health services, a number of Central Asian countries declared their political will to reform health care systems to improve access to quality health services based on primary health care.

of the sudden and unexpected demise of the Union. The governments of the newly independent states were confronted, almost overnight, with the task of assuming direct responsibility for a huge range of administrative, economic, social and environmental problems. Some of these problems are shared by all the former Soviet republics. However, in Central Asia they are more acute because of the lower level of development and the more critically balanced social and environmental conditions. During the Soviet period these republics were to a large extent dependent on all-Union economic structures and on assistance from the central government. Social services were largely funded by central government subsidies. Also, the high degree of specialisation in the production of raw materials had created lopsided economies; this in turn caused a far higher degree of inter-republican trade than was to be found elsewhere in the Union.

The most precipitous drop was noted in Tajikistan and Turkmenistan to a quarter and less than half of pre-independence levels, respectively. Despite the fact that public spending for the health sector has significantly contracted, there has been little change in medical staffing and in-patient capacity in the public health sector during the transition. Facing the growing costs of health services, a

number of Central Asian countries declared their political will to reform health care systems to improve access to quality health services based on primary health care. Given the current preoccupation with curative care and problems of declining health among people, governments find it tough to integrate health promotion objectives into policies and adequately address the HIV/AIDS issue.¹²

During the past 10 years, profound outbreaks of infectious diseases have occurred in the Central Asia region. A recent typhoid epidemic in Tajikistan, tuberculosis (TB) in all CAR, the resurgence of malaria in Tajikistan and Turkmenistan, and leptospirosis infection in Kazakhstan, reflect the need for increased epidemiological capacity in the region. Poor treatment practices, lack of understanding of basic principles of epidemiology and insufficient local and regional disease outbreak response systems and lack of pharmaceuticals are causing burgeoning disease problems. There is an exceptional need to build the capacity of local ministries of health (MOHs) in basic epidemiology, biostatistics, and disease surveillance.¹³

A grim mosaic

Kazakhstan: Take the case of Kazakhstan, a state that became independent after the break-up of the Soviet Union in 1991. The demise of the old regime gave a huge blow to its heavy industry production. The regime change, coupled with drastic economic policy changes and social turmoil, brought about drastic shifts in people's health status. Number of hospital beds began to be significantly reduced since 1993 but now it is comparable to the European region. The level of hospitalisation and outpatient visits also drasti-

cally came down since late 1980s. Population outflows tripled between 1991 and 1997, some 16.5 per 100 population and 35 per cent higher than the growth.¹⁴

Estimates suggest there are 20,000 HIV/AIDS cases here. The syphilis incidence rate has taken epidemic proportions since 1993, rising 200-fold between 1990 and 1997. During 1985-86, President Gorbachev's anti-alcohol policy led to a rise in life expectancy, which again sharply fell during 1992-97. Mortality due to cardiovascular diseases rose since 1992. Incidence of illicit drug use rose six times between 1990 and 1996.¹⁵ The prevalence of HIV amongst the injecting drug users in Kazakhstan varied from one to eight per cent in different cities, their estimated total number being 250,000, most of them sharing needles and having unprotected sex.¹⁶

Kazakhstan is currently creating a legal and public climate conducive to protection of people with HIV/AIDS. Legislation on HIV/AIDS provides for preventive measures by the Government and guarantees fundamental rights of people affected by the disease. A National AIDS Coordinating Committee was established eight years ago. HIV/AIDS prevention measures have been integrated into a strategic plan of development of the Republic of Kazakhstan up to 2010. The Global Fund has committed \$22.4 million dollars for five years for HIV/AIDS work in the country.

Kazakhstan Foreign Affairs Minister, Kassymzhomart Tokaev, said at a recent UN meet: "Even with a relatively low incidence of HIV/AIDS, we are well aware that without deep involvement in the international cooperation on this extremely important issue, this di-

Migration and subsequent separation from families is often associated with changed sex patterns and increased vulnerability to HIV.

sastrous disease will seriously affect internal stability in Kazakhstan, ...the highest priority of our politics."¹⁷

Kyrgistan: In Kyrgistan, social and economic reforms have led to a deteriorating economy like in most Central Asian countries. Mortality due to infectious diseases and parasitic diseases remain very high, tuberculosis rates increasing sharply since 1994. There is high mortality due to viral hepatitis and syphilis. After falling by almost one-third between 1992 and 1997, hospital bed rate is now reaching the European average. Indicators of health service utilisation have also fallen sharply.

About a tenth of the population, that is about 500,000 people, emigrated during 1990–97. Worsening living conditions and poor job prospects are making people migrate from the mountainous regions of the country to the valley and the capital city. Migration and subsequent separation from families is often associated with changed sex patterns and increased vulnerability to HIV. There has been an increase in morbidity due to drug abuse between 1990 and 1997 from 3.7 to 18.8 per 100,000. The first HIV case among nationals was registered in 1996.¹⁸

Uzbekistan: Tuberculosis and syphilis rates have increased in recent years in Uzbekistan as well, but not as sharply as in the average of CAR.



Health services remain poor in war-torn Afghanistan

The first HIV case was registered in 1987, among foreign students from Africa and Asia. By 1998, the registered cases grew to 51. Uzbekistan today has about 1,750 officially registered HIV-positive cases. "Over the past four years there has been a 35-fold increase in HIV cases," says Aziz Khudayebardiev, the UNAIDS national programme officer in Uzbekistan.¹⁹ "Until 1999, HIV was mainly transmitted sexually, now the disease is mostly contracted through injecting drug use," he notes. Some 53 per cent of HIV-positive people contracted the disease by way of needle sharing.

HIV spreads so quickly that once it is introduced into a particular drug-using population, 40 to 60 per cent of it will contract the disease within two to three years.

There are 27,000 registered drug users in the country, but independent assessments put the figure at 12,000 for Tashkent alone. About 85 per cent of those infected are men. Only 10 children were reported infected.²⁰ In Tashkent, Yang Yul and Samarkhant, prevalence levels have reached 25 per cent. Most of the infected people are aged between 15 and 30 years.

Prevalence of HIV is rapidly rising.²¹

The UN Office for Drug Control and Crime Prevention recently estimated that there were 90,000 drug users in the country. According to the agency, HIV spreads so quickly that once it is introduced into a particular drug-using population, 40 to 60 per cent of it will contract the disease within two to three years. "After its concentration among intravenous drug users, HIV is spreading to the general public through heterosexual contacts, according to UNAIDS data. That means there is potential for large-scale sexually transmitted

HIV/AIDS epidemic in Uzbekistan. This is especially worrying considering the fact that the country's population is predominantly young."²²

Uzbekistan enacted a new legislation in 2000 to address the needs of risk groups, but it has yet to be implemented. Though the government is supposed to provide medicine for people with HIV/AIDS, drugs are not easily available. There is an increase in high-risk behaviour among young people, including unsafe sexual intercourse and injecting drug use. International groups note that lack of transpar-

ency in the government often hinders intervention programmes.

Turkmenistan: Only a few HIV positive cases have been detected in the country, but the surveillance system is poor and, therefore, it is not known what the actual number is. Several factors in Turkmenistan create grounds for a potential AIDS epidemic including widespread injecting drug use, commercial sex work and sexually transmitted infections. Morbidity due to syphilis has increased more than seven-fold, in comparison to the early 1990s. With high rates of sexually transmitted infections and increasing injecting drug use among young people, there is a real threat of a rapid increase in HIV/AIDS prevalence.²³

In Turkmenistan, systematic activities aimed at HIV/AIDS prevention and control began in the late 1980s. In 1989, the government established an AIDS control system, coordinated by a committee convened at the health ministry. In addition, HIV/AIDS prevention issues are addressed by a number of governmental structures within the ministries of education, culture, defence and internal affairs. In 1999, the health ministry approved a control programme for 1999–2003.²⁴

On January 10 of 1991, a law on AIDS Control was passed, covering issues such as testing and certification, confidentiality of medical information, and the rights and responsibilities of the people with HIV/AIDS. On July 7 of 2001 it was replaced by a new law, making available medical, so-

cial, psychological and financial assistance, human services and governmental guarantees to people with HIV/AIDS. The law offers them unconditional access to medical care, free prescription drugs and reimbursement of travel costs within the country for health needs.²⁵



Rebuilding health: a major task in Afghanistan

Tajikistan: In Tajikistan, as of December 31, 2002 only 75 registered cases of HIV and one case of AIDS were reported – 43 were persons younger than 29. Surveillance is poor and reporting is unreliable. For the health authorities the main concern is the spread of AIDS among injecting drug users (IDUs).²⁶

Drug trafficking and abuse pose a major risk in Tajikistan. The contributing factors include civil war, a dramatic deterioration in the socio-economic situation of most population groups, proximity to drug spots in Afghanistan and Pakistan and porous borders. A lack of clearly defined customs regulations and law enforcement

agencies' inexperience in combating the drug mafia are causes for concern. As drugs are transported through Tajikistan, some portion of them remains there and is dispersed throughout the country, leading to a high degree of hidden drug use and addiction. The quantities of raw poppy seeds seized in-

dicate that heroin production laboratories may now exist in Tajikistan. The Open Society Institute estimates that 10 per cent of the drugs being produced and trafficked are consumed within the country.²⁷ It is particularly worth noting that in recent years the incidence of drug addiction morbidity has increased.²⁸ Besides drugs often have nexus with sex trade, further worsening the HIV risk in the region.

Azerbaijan: Despite a ceasefire in place since 1994, Azerbaijan has yet to resolve its conflict with Armenia over the

Azerbaijani Nagorno-Karabakh enclave (largely Armenian populated). Azerbaijan has to support some 750,000 refugees as a result of the conflict. Corruption is ubiquitous and the promise of wealth from Azerbaijan's undeveloped petroleum resources remains largely unfulfilled. Officially, 573 persons are currently living with HIV in Azerbaijan, 551 of them nationals, and 22 foreigners – 428 (77.7%) are men. Till now, 44 nationals have died and 43 are at the last stage of infection. 265 HIV infected persons are migrants, those who stayed and worked abroad for a long time and returned mainly for marriage. The National Centre to Combat AIDS (NCCA)

advises migrants to undergo medical examination upon returning.²⁹

In 1992, the Azerbaijan Republic established NCCA. A law for HIV prevention was enacted in 1996. It aims to strengthen the logistical base of AIDS prevention service. And it provides for social support of HIV-infected citizens, including free-of-charge travel up to the place of treatment and back. In the last five years the health ministry has issued six decrees and seven methodical instructions on prevention of HIV/AIDS, including provision of full access to the anonymous treatment in public and private clinics of all cities, regions and communities of Azerbaijan. Azerbaijan has signed the UN declaration of commitment (to fight HIV) and the 'urgent measures programme' of the CIS member-states in 2002.

All secondary and higher educational institutions have been holding special classes under the 'Save yourself from AIDS' programme for 10 days from every December 1, the World AIDS Day. Lack of funds and equipment as well as lack of public disclosure and openness on HIV infections, especially in rural areas, hamper the government programmes.³⁰

AIDS in the time of poverty

The ingredients that make the AIDS time bomb are available in abundance in the region. Socio-economic causes play a very important role in making the region, especially its poor people extremely vulnerable to HIV infection. Sudden political and economic shifts in the post-Soviet era have had multiple impacts on the Central Asian society. Diminishing budgets for the social sector,

including the health infrastructure have had a crippling effect. Meanwhile, biting poverty provided an added factor to falling health standards of people in general. Add to that an increasing mass migration within and outside the country with its often-associated impacts, such as separation of families, changing sexual habits, prostitution and human trafficking. Probably the worst top up to such an explosive situation was prevalence of injecting drug use, to which the above factors have contributed to a large extent. Lack of good governance has led to a proliferation of drug cartels – which also often

Sudden political and economic shifts in the post-Soviet era have had multiple impacts on the Central Asian society. Diminishing budgets for the social sector, including the health infrastructure have had a crippling effect. Meanwhile, biting poverty provided an added factor.

spun off sex trade rackets – that pushed and peddled drugs across the region and outside. Often there have been spillover trade, consumption and addiction along the drug tracks.

Drug nexus: Central Asia is a critical drug trafficking route, the corridor through which much of the world's hard drug trade from Afghanistan, Pakistan and from within the region, is conducted. The region is estimated to contain approximately 500,000 drug users. Illicit drug trafficking, while a serious problem in many countries, takes place most efficiently in settings where the following conditions exist: proximity to production zone; porous borders; and poverty and corruption.

The government of Tajikistan has acknowledged that security forces are often corrupt. In the southern regions of the country,

many border guards are involved in the drug trade and the local population has made numerous complaints of harassment and abuses committed by them. Traffickers include individuals who rose to positions of power and wealth as field commanders during the Tajik civil war, the 'warlords'.³¹

One striking piece of evidence for the impact of drug trafficking through CAR is the explosion of HIV among IDUs in Russia, Ukraine and Belarus, which are both destination markets and transit routes as drugs flow to Western Europe. In a study, it was shown that economic factors were

also responsible for many people initiating drug use, due to stress, boredom and unemployment (ibid). An often overlooked factor that leaves a track of HIV infection along drug routes

is the nexus between narcotics trafficking and sex trade. For instance, over 1000 women were trafficked from Tajikistan in 2000. Many of the women involved become users themselves, exponentially increasing their risk of HIV.³²

World Bank estimates indicate that the region has almost 0.5 million drug users with a growing number depending on injecting drug use, one of the most potent methods of transmission of HIV/AIDS.

- Kazakhstan has around 200,000 drug users, almost half of whom would be injecting drug users (IDUs)
- Tajikistan has around 100,000 drug users with some 25 per cent being IDUs
- Uzbekistan and Turkmenistan have around 60,000 drug users, with more than 50 per cent being IDUs in Uzbekistan and 15 per cent in Turkmenistan.

- In the Kyrgyz Republic, the deputy health minister has reported that there are 4,500 persons currently registered as drug addicts nationally, but that the real figure is likely to be ten times higher.³³

Children hit: An important demographic feature of the sub-region is the prevalence of young age structure that the Central Asian countries continue to have over the transition. The five Central Asian countries contain over 23 million children – one-fifth of all the children in the 27 countries of Central and Eastern Europe and CIS.³⁴ Within Central Asia, the population under 18 represent about 43 per cent of the total population ranging from 35 per cent in Kazakhstan to 47 per cent in Tajikistan.³⁵ Young people should be placed into a focus of HIV/AIDS, STD and drug abuse prevention activities in the sub-region due to their vulnerability for both socio-economic and behavioural reasons.

The populations in Central Asia are expanding quite rapidly. Given that marriage in Central Asia was, until recently, virtually universal, falling marriage and birth rates may reflect a lack of confidence in

the future that affects individual's decision to marry, divorce and have children. The rise in divorce between 1991 and 1995 has been modest in Tajikistan and Uzbekistan but more pronounced in Kazakhstan (13.5%), Kyrgyzstan (17.4%) and Turkmenistan (25%). Familial relations are seen to be traditionally strong in Central Asia. Falling marriage and higher marital breakdown, thus, are other factors that stem from the transition and social distress in Central Asia and should be seen in the HIV/AIDS context as they influence individual behaviour and vulnerability.³⁶

Migration: Important demographic changes in Central Asia have also been due to large population movements. According to estimates by the UN High Commissioner for Refugees, over four million people have moved within or from Central Asia since the late 1980s. Among these, 700,000 were displaced during the civil war in Tajikistan (most of whom have returned since); 250,000 have left ecological disaster areas such as the Aral Sea, and around two million have returned to their ethnic 'homelands' outside the Central Asian region, in addition to large movements within countries.

"Migration issues are definitely related to HIV and AIDS. Migration will not stop as long as wide economic imbalances persist, and HIV/AIDS vulnerability factors for migrants are similar across the world," says Joost van der Aalst, country director of International Organization for Migration (IOM), Azerbaijan. A related issue is trafficking. IOM studies in Azerbaijan show trafficking can make people vulnerable to HIV/AIDS. Opening of the Baku-Tbilisi-Ceyhan Oil pipeline will bring an impetus to the economic development in the region, increasing cross-border movement between Turkey, Azerbaijan and Georgia along with risks of human smuggling and trafficking, Joost notes.

A fight on all fronts

UN assistance in the field of HIV/AIDS and STD prevention has been provided to Central Asian countries starting 1994, initially under the WHO Global Programme on AIDS (1994–95). Since 1996, UN support in this field is being led by UNAIDS and its co-sponsors through UN Theme Groups on HIV/AIDS backed up by ICPA, stationed in Kazakhstan.³⁷ UN theme groups in Central Asia relatively quickly moved from initial set-up and information exchange stage to establishing a close dialogue with governments and then to more coordinated action focusing on advocacy, programme frameworks development and resource mobilisation.

A notable example of the progress achieved by the UN Theme Group in bringing coordinated effort into an advanced form of integrated planning and joint implementation of multi-donor activities is the experience of the groups in Kazakhstan which illus-



A class of Afghan refugees living in Iran

War on health

Devastated by 24 years of war and associated calamities including internal conflict, a flourishing drug trade, a bankrupt economy and broken infrastructure, Afghanistan's health scenario is dismal. The country has produced the maximum number of refugees in recent history – 5.5 million. Its terrain is pockmarked with live landmines; a lingering drought and an earthquake have added to the misery of its people.

Officials note that out of a population of 22 million, there are only 15 confirmed cases of infection – six local residents and the rest expatriates deported, mostly from the Middle East, on account of their HIV status.¹ Afghanistan's protracted conflict,² its extremely poor socio-economic indicators denoted by a bottom place in the UNDP Human Development Index, and the low status accorded to women indicate that the country has high vulnerability to the infection.³ Besides, statistics from neighbouring countries and the massive movement of people may further contribute to infection.

All the 15 cases contracted the infection through heterosexual sex, officials note. Nonetheless injecting drug use could also be a serious factor, given Afghanistan's status as one of the world's largest producers of opium. A recent study completed by the UN Office on Drugs and Crime (UNODC) estimates that there are currently more than 10,000 opium and 7,000 heroin users in Kabul city alone, possibly a large section of them intravenous drug users. Reliable reports from drug treatment centres in Kabul suggest that many users share needles or syringes.⁴ Sex workers are at risk. Besides, there have been reports about some refugee women getting sexually abused or

turning into sex workers. Blood safety is another crucial issue with only 30 per cent transfused blood being screened, as WHO has estimated.

In Afghanistan, HIV surveillance mechanisms are virtually non-existent. The HIV department of Afghanistan's Ministry of Health has limited resources. Dr Naqibullah Safi, senior advisor to the ministry and manager of the government's HIV/AIDS department said: "There is only individual knowledge out there...and of course this affects behaviour."

Still the ministry is beginning to network with other agencies such as the counter-narcotics department and UN groups. The HIV/AIDS department has initiated discussions with international humanitarian assistance groups about an awareness programme. And the first draft of a safe blood strategy and HIV prevention policy is now being discussed, even as the government promotes basic HIV education in schools with the help of UNICEF. The central blood bank recently held a training programme on safe practices. Some NGOs are also involved. As Dr Safi succinctly put it: "We are already late."

Afghanistan, a country where livelihoods are already fragile, cannot afford another disaster as an AIDS epidemic. Besides, in the context of post-conflict 'nation-building' and new legislation, there should be a law to prevent discrimination against HIV infected people.

1. Verbal information provided by Dr Naqibullah Safi, Senior Advisor to the Ministry of Health
2. Evidence from other regions suggests that HIV thrives in conflict areas.
3. Government of Afghanistan, *HIV/AIDS & STI National Strategic Plan*, June 2003
4. UNODC (2003), *Community Drug Profile #5 – An assessment of problem drug use in Kabul City*, July, 2003

trates also the successful approach towards co-opting other donors and expanding the resource base for HIV/AIDS-related programmes.

Prior to the emergence of development projects supported by

UNAIDS and its co-sponsors, Central Asian countries were targeted by UNAIDS-facilitated assistance that included wide range of advocacy and capacity building workshops and seminars in-country and for the sub-region.

In international discourse often the big picture is missing. The World Bank briefing paper, for instance, highlights the following aspects of injecting drug use:³⁸

- i) Central Asia is a critical drug trafficking route

Reaching grassroots

The first HIV case in Iran was reported in 1986 and 4442 cases were notified between 1986 and 2002. However, there are an estimated 20,000 persons with HIV/AIDS in the country. The adult prevalence rate is estimated to be below 0.01 per cent. Of the reported cases, 66 per cent are IDUs, 62 per cent aged between 25 and 44. About 95.5 per cent cases are male. About five per cent of those tested through free voluntary tests in the primary health centres (PHCs) in 2001 were positive, according to WHO statistics.¹

HIV appears to be accelerating fast. According to the National AIDS Programme reports, 1159 newly diagnosed HIV/AIDS cases in 2001 shows a three-fold increase in comparison to 2000 and 1999. Injecting drug use drives the epidemic. In 2001, 64 per cent of all cases were from IDUs. The data is variable as it relates to occurrence of well-known outbreaks among IDUs in prisons. Consequently, HIV rates among prisoners rose up to six times higher in 1999 compared to 1996.² Global fund has allocated a total of US\$5,698,000 for two years for Iran.³

The vibrant PHC network that serves 18 million people in Iran, mostly in poor areas, can serve as the best insurance against the epidemic. Free, confidential tests and care of HIV infected people and 'high-risk groups' are handled at health centres. The government built over 8,800 Health Houses, 600 Rural Health Centers, 430 Urban Health Centers (UHCs) and 147 *behvarz* (woman health worker) training centres between 1985 and 1991.⁴ The PHC system now has over 16,200 'health houses' in addition to mobile units. In the cities, 'health posts' support an estimated one million women volunteers who provide health education and collect data. "The effective coverage system of primary health care interventions in Iran represents the main contributor to a changing

health and environmental pattern in the country," says Dr M Pezeshkian, Health and Medical Education Minister, Islamic Republic of Iran.

Between 1998 and 2000 Iran has made major advances:

- i) Access to primary health care services increased from 60% to 95%.
- ii) Access to safe drinking water increased from 78% to 92%.
- iii) Access to adequate excreta disposal increased from 28% to 82%.

During the same period, health indicators improved as follows:

- i) Infant mortality rate reduced from 45 per 1000 to 28.6 per 1000.
- ii) Under 5 mortality rate decreased from 56 per 1000 to 36 per 1000.
- iii) Maternal mortality rate reduced from 90 per 100,000 to 45 per 100,000.⁵

At the same time, the PHC network suffers from a number of weaknesses. Many of them now lag behind in facilities. Frequent absence of basic laboratory and radiology facilities in many UHCs cut down their efficacy. Referral system has to be more efficient. Lack of proper workspace and laboratory facilities further aggravate the problems. PHCs have to be more proactive in dealing with HIV/AIDS.

1. Statistics compiled from World Health Organisation Eastern Mediterranean Regional Office
2. Spasdi (2003) <http://www.spasdi.org/e/article/epid.pdf>.
3. Global Fund (2003) <http://www.globalfundatm.org/proposals/round2/approvedproposalsprint.html>
4. 'Iran: the Present and Future of Primary Health Care', Dr Mohammed Ali Barzgar and Dr Ravi Narayan in *Health for All Now! Revive Alma Ata*, Books for Change, 2003
5. WHO (2003) Statement by: H. E. Dr M Pezeshkian, Health and Medical Education Minister of the Islamic Republic of Iran, before the Fifty-Sixth World Health Assembly On the Adoption of the Framework Convention on Tobacco Control, Geneva, 20 May, 2000.

The vibrant PHC network that serves 18 million people in Iran, mostly in poor areas, can serve as the best insurance against the epidemic

Dangerous roads

Migrant people can be more vulnerable than local populations during their movement and they can spread HIV upon their return home. Better knowledge of what factors in the migration context play a role in increasing the risk and vulnerabilities of migrants will help in identifying policy and programme needs. The International Organization for Migration (IOM) is currently drafting an HIV/AIDS policy document, as its global experience confirms that for the mobile population groups in Central Asia region and elsewhere, potential epidemic risk of HIV/AIDS and sexually transmitted infections (STIs) is the clear and present danger.

Data from various studies on health demonstrate that migrants tend to be disproportionately affected by epidemics, especially HIV. Victims of trafficking are even more at risk as they may not know about controlled means of protection, or even have access to health care. Limited access to the means of protection considerably increases that risk. Early sexual activity and multiple partners are risk factors for STIs. Gender clearly affects the degree of risk and exposure to HIV/AIDS. And trafficked persons are more often deceived or coerced into situations of sexual exploitation and exposed to HIV. The limited data available shows that migrant populations miss out on both HIV/AIDS prevention and treatment.

Rather than concentrating on screening, efforts should be directed towards improving health

conditions in countries of high HIV prevalence. Efforts should also be directed towards reducing vulnerability factors and improving living conditions in transit and destination countries and providing access to health care and social support services for all migrants.

IOM, in cooperation with Organization for Security and Co-operation in Europe (OSCE), has drafted a national action plan on counter-trafficking focussing on protection of the affected people, prosecution of traffickers and improvement of the trafficking-related legislation. One of the main components to protect those affected is the provision for secure accommodation and good access to medical support (both general practice and psychological).

There is a need for community-based approaches that address the needs of different sections of migrants, especially women. Of course, there is a need for both good data and for joint statements on policy issues such as stopping mandatory HIV testing of immigrant people.

Key recommendations in this context include:

- Promote multi-sectoral approach in response to HIV/AIDS
- Combat trafficking in persons
- Conduct targeted awareness-raising among mobile population groups.

(Compiled from information provided by International Organisation for Migration, Azerbaijan)

- ii) Poverty is fuelling drug trade in Central Asia
- iii) Poverty is fostering an increase in drug use (drugs are often cheaper than vodka)
- iv) Culture of fear.

But it does not analyse the breakdown of the health system owing to sudden introduction of market reforms and budget cut in social sector spending. Besides, issues such as drug pricing and rising treatment costs find little men-

tion in the report. The political economy of disease and disease control is often not highlighted.

To wipe out a menace

The complex HIV/AIDS situation in the region calls for a multi-pronged response:

- a. Recognise the multiple causes and consequences of the HIV menace, a pro-people response strategy is a must. Since HIV is an emerging issue in the region,

public awareness is a prerequisite to understand the scope of the problem and its socio-economic dimensions. Responses must be planned accordingly.

- b. People should be put before profits. Make sure that structural adjustment policies do not affect public health and social safety nets. The pattern in the CAR shows that reforms often exacerbate poverty at least in the initial years. Biting

poverty spins off problems like migration, drug and alcohol abuse and even human trafficking – all of which contribute to health problems, especially HIV. Besides, treatment methods should be made affordable to poor people.

- c. Strengthen primary health care and ensure community care for the HIV/AIDS-affected persons. This is the best insurance against this emerging epidemic scenario.

Endnotes

1. Joint UN Programme on HIV/AIDS, UN-facilitated Response to HIV/AIDS, STD and Drug Use in Central Asian Countries, 1996–1998, www.unaids.org
2. CDC (2003a) Strategy for Intensifying Action Against AIDS, Centre for Disease Control (CDC)
3. World Bank (2002): *HIV/AIDS in Central Asia*, briefing note prepared by Laura Shrestha, former ECA AIDS focal point, in 2001, and updated by Joana Godinho in 2002,
4. IRIN (2002), *Central Asia: HIV/AIDS growing rapidly*, UN Integrated Regional Information Network, Press statement dated, July 9, issued from Islamabad, 2002 <http://www.aegis.com/news/irin/2002/IR020706.html>
5. World Bank (2003a), *Averting AIDS Crises in Eastern Europe and Central Asia*, Washington DC: World Bank
6. Stachowiakm J *et al* (2003) *HIV follows heroin trafficking routes*, Johns Hopkins Bloomberg School of Public Health http://www.eurasianet.org/health/security/presentations/hiv_trafficking.shtml
7. World Bank (2003a)
8. World Bank, (2003b), Press statement issued on 16 September, 2003, on the occasion of the launch of *Averting AIDS Crises in Eastern Europe and Central Asia*, Washington DC: World Bank
9. IRIN (2002)
10. UNAIDS (2002), Report on the global HIV/AIDS epidemic, UNAIDS

11. UNDP (1998) *Poverty in Transition?* UNDP Regional Bureau for Europe and the CIS, quoted in UNAIDS, 1999
12. UNAIDS/WHO (2003) The UNAIDS/WHO Global HIV/AIDS Online Database, <http://www.who.int/GlobalAtlas/home.asp>
13. CDC (2003a)
14. WHO (2003b) Highlights of Health
15. *ibid*
16. IRIN (2002)
17. (UN, 2003). Statement by H.E. Mr. Kassymzhomart Tokaev, Minister of Foreign Affairs of the Republic of Kazakhstan at the high-level plenary meeting devoted to reviewing progress in implementation of the Declaration of Commitment on HIV/AIDS, 22 September, New York, taken from <http://www.un.org/webcast/kazeng030922.htm>
18. World Bank, (2003b)
19. IRIN (2003), <http://www.irinnews.org/webspecials/aids/uzbekistan.asp>
20. *ibid*
21. UNAIDS (2003) National Response briefs
22. IRIN (2003)
23. UNAIDS (2003) National Response briefs
24. ILO (2003), www.ilo.ru/aids/docs/dec02/cis/Turkmenistan
25. *ibid*.
26. UNGASS (2003). Follow up to the Declaration of Commitment on HIV/AIDS, Country Report Format, Reporting Period Jan-Dec 2002).
27. Stachowiakm J *et al* (2003)
28. OSIAP (1999), *Women and Drugs in Tajikistan*, Open Society Institute Assistance Foundation – Tajikistan
29. NCCA (2003), Press releases issued by the National Center to Combat AIDS, on October 1, 2003, Azerbaijan: NCCA
30. Joost (2003) Email interview with Joost van der Aast, country director of International Organisation for Migration (IOM), Azerbaijan

31. Stachowiakm J *et al* (2003)
32. Stachowiakm J *et al* (2003)
33. World Bank, (2003b),
34. UNICEF (1998a) Education for All. The MONEE Project, CEE/CIS/Baltics. Regional Monitoring Report No.5
35. UNICEF (1998b) The Progress of Nations, UNICEF
36. UNAIDS, (1999): AIDS Epidemic Update, UNAIDS
37. *ibid*
38. World Bank, (2003a)

References

- King Maurice, ed (1983), *The Iranian Experiment in Primary Health Care*, The West Azerbaijan Project, School of Public Health, Ministry of Health and Social Welfare, Teheran, Oxford: Oxford University Press
- Ministry of Health and Medical Education (2003), *Health Situation and Trend in the Islamic Republic of Iran*, Teheran 2003,
- Sadeghipour H (2003), Vice chancellor for health affairs at the Tehran University of Medical Sciences (TUMS), quoted in the Harvard University web site (<http://www.hsph.harvard.edu/now/jan24/iran.html>)
- Shadpour (1994), *The PHC Experience in Iran*, The Council for Expansion of PHC Networks, Teheran: Ministry of Health and Medical Education, UNICEF
- UNAIDS (1999), Joint UN Programme on HIV/AIDS, UN-facilitated response to HIV/AIDS, STD and Drug Use in Central Asian Countries, 1996–1998, Kazakhstan
- UNAIDS www.unaids.org
- WHO (2003), Global AIDS treatment emergency, Factsheet 274, September 2003-10-24
- <http://www.who.int/mediacentre/factsheets/2003/fs274/en/>
- CDC (2003) Background paper on activities in Central Asia, Centre for Disease Control (CDC) <http://www.cdc.gov/epo/dih/centralasia.html>



UNIKRISHNAN P.V

Blunt remedies

Surveillance pays, but undermines rights

Due to the lack of good studies and sometimes deliberate attempts of governments to ignore the problem, estimates are far from accurate

East Asia¹ is a tapestry of dramatically different cultures, lifestyles and income levels. The region includes Japan, the economic giant, and China, the largest country in Asia and the most populous in the world, home to a quarter of its people. Hong Kong, a Chinese Special Administrative Region, is a thriving international trade hub unlike the vast agrarian provinces of the Chinese mainland. Per capita Gross Domestic Product (GDP) counts vary widely with Hong Kong boasting the world's 11th rank, Japan (14th), Taiwan (44th), and South Korea (46th) far wealthier than China (133rd) Mongolia (173rd) and North Korea (206th) trailing far behind.

Published statistics may make East Asia, except parts of mainland China, look like a 'low prevalence' area, estimates placing the number of cases of HIV infected people in East Asian countries at less than 8,74,099 at the end of 2001.² Due to the lack of good studies and sometimes deliberate attempts of governments to ignore the problem, these estimates are far from accurate. Unofficial estimates place the prevalence rate at much

higher levels. Worse still, data show a rapid increase in some of the countries, though policymakers still tend to consider HIV as an 'alien' threat and impose discriminatory, if not draconian, rules in the name of preventing it. Migrants in search of jobs in the 'Tiger' economies in the region are often discriminated against and harassed, even as human trafficking and sex rackets flourish, fuelled by affluence as well as poverty.

Number game

China: According to WHO reports, per capita government expenditure on health in 2000 was US\$17. But there is concern that the government is rapidly disengaging itself from public health care services since the economic reforms started in 1979. The total health expenditure of the Chinese mainland in 2000 was 5.3 per cent of its GDP.

Health care systems and access to it differ vastly among various regions. Remote areas with least availability and access to health care services record comparatively higher HIV/AIDS prevalence rates. According to Daniel Chin, a Hong

Grim scenario

The minimum estimated number of cases of HIV infected people in East Asian countries at the end of 2001.³

	Total	Women	Children	Deaths	Total Population In million	Per capita GDP/GNP (US\$)
China (mainland)	850,000	220,000	2,000	30,000	1200	783
Hong Kong	2,600	660	<100	<100	7.2	25400
Japan	12,000	6,600	110	430	127	54900
Mongolia	<100	N. A	N.A	N.A.	2.5	1780
North Korea	N.A	N. A.	N.A.	N.A.	23.7	1000
South Korea	4,000	960	<100	220	52.7	16100
Taiwan	5399	378	NA	899	22.0	17400

Kong-American doctor working for the WHO in Beijing: "The public health programme in China is in a shambles. It's under-funded, understaffed, and basically the poor, who have the most to benefit from public health are being left out of the picture."

China has started giving free anti-retroviral treatment to a few people with HIV/AIDS. With the inadequate infrastructure, lack of trained doctors and social workers, and poor supervision, there is a risk of developing drug-resistant 'super-infections' that could spread to other places.⁴ China's executive minister of health, Gao Gang said that the infections mostly spread through unsafe blood transfusions in the central provinces of Anhui and Henan during 1993–1995.⁵ By the end of 2002, the Chinese government had documented 40,560 cases of HIV infection but estimated that one million could be infected nationwide.⁶

The Chinese government has recently launched HIV prevention and awareness projects in Beijing and made the right noises about non-discrimination, though it has yet to be seen acting on that front (see box on China, pp42–44).

Hong Kong: HIV was first diagnosed in late 1984 and by July 2003 the total number of reported cases grew to 2,116.⁷ Every year, as much as 70 per cent of new HIV positive cases are notified under the Health Department's voluntary reporting mechanism. The most important infection route remains sex, largely among people aged between 25 and 34. In 2000, less than five per cent of the reported infections were attributed to injecting drug use. There are, however, indications that HIV rates among injecting drug users is on the rise. Frequent cross-border travellers between Hong Kong and Southern China have also been identified as population groups that deserve targeted HIV prevention.

Japan: HIV prevalence rate in Japan continues to remain well below one per cent after the first HIV case was reported in March 1985. By 1996, almost 4,000 persons were found infected with HIV, and over 1,000 had developed AIDS. More recently, unprotected sex has been a major cause for HIV transmission in Japan, accounting for about 78 per cent of new infections in 2000. By the end of 2002, the government identified 12,595

persons with HIV. Experts fear that the actual number of Japanese infected with HIV is probably about five times higher.

Health experts say this number could increase to 50,000 by 2010 – fuelled by a booming \$13 billion-a-year sex trade, declining condom use, lack of awareness, increased sexual activity among young people and the low status of women in the traditional Japanese society.⁸ Persons with haemophilia, a disorder that slows down blood clotting suffered the infection far more than any other vulnerable group, accounting for 55 per cent of the HIV/AIDS cases by mid-1990s. Virtually all the infections among haemophiliacs have been linked to HIV-infected blood products that Japan had imported from the United States a decade ago.⁹ Since 1990, this proportion has been dipping with the introduction of safe, heat-treated blood products.

A disturbing new trend in Japan is that people in their teens and 20s account for nearly 40 per cent of all those newly infected with HIV during 2001.¹⁰ It is believed that the increase is spurred by their casual attitudes toward sex, coupled with misconceptions

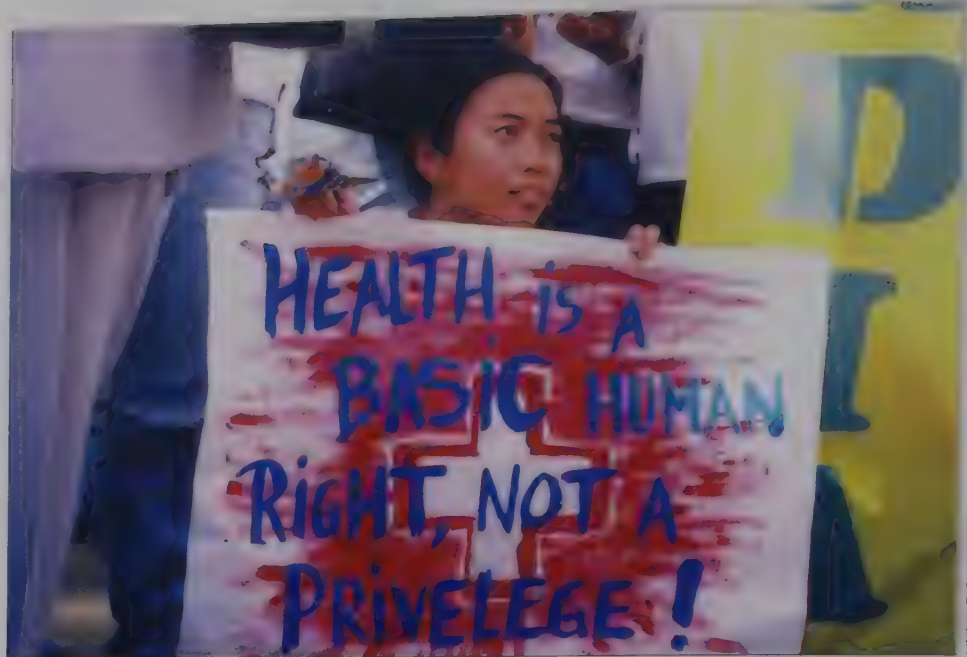
about the risks. Prejudice against people with HIV/AIDS also discourages many young people from getting tested for the virus.

Mongolia: This landlocked country between China and Russia, fabled for its remoteness and traditional lifestyles, was thought to be cocooned from HIV. It also has one of the best health recording systems. However, the situation may be changing due to rapid socio-economic changes, breakdown of the public health system, increasing rates of prostitution (even among children), an alarming increase in sexually transmitted diseases in young people, and a pincer attack of the virus from its more prevalent areas in China and Russia.

The first HIV case was reported in 1992 in a man who acquired it abroad, the second in 1997. By 2000, there were fewer than 100 HIV infections as per official estimates and no more till 2002 end. High risk population' made up only 1.5 per cent of those tested.¹¹ The question is whether it is the virus that is spreading slowly or the news about it.

Despite the fact that there is reportedly low HIV prevalence in Mongolia, there is no room for complacency. Sexually transmitted infections seem to be on the rise here, setting a fertile ground for HIV. The 1998 reproductive health survey noted that the contraceptive prevalence rate was 65.8 per cent. Official statistics show that there were 12.4 cases of gonorrhoea and 5.5 cases of syphilis per 10,000 people in 1997, rising partly due to lack of access to condoms and lack of awareness.¹²

North Korea (Democratic People's Republic of [DPR] Korea): North Korea has a centrally planned command economy, based largely on heavy industries



Health activists demand health as a right

and agriculture. Lack of information flow from the DPR Korea makes it difficult to describe the real situation on HIV/AIDS in the country. According to a UN report, there were fewer than 100 people with HIV in the country till 2000.¹³ International health workers say the North Korean government is trying to learn from neighbouring China, a country that began public discussion on the subject only recently. In reality, little is known about the situation.

South Korea (Republic of Korea): HIV in South Korea was first detected in 1985. At the end of 2001, there were 4,000 cases, or 0.01 per cent of people aged between 15 and 49. Some recent surveys indicate an increasing trend (reaching up to 17 per cent) of unprotected sexual activity among high school students. Official statistics show that men account for nearly 89 per cent of the people with HIV, most of them in the 15 to 35 years age group. Korea's National Institute of Health (NIH) reports that about 97 per cent of all South Koreans with HIV contracted it sexually – 67 per cent from heterosexual intercourse and 30 per cent from homosexual intercourse.¹⁴

NIH blames the declining use of condom and low awareness levels for the spread of the disease. Besides, there is concern about sex trade, which the Korean Institute of Criminology calls a 'business' worth US \$20 billion, equivalent to 4.1 per cent of the nation's GDP in 2002. To control prostitution, officials are considering legalisation. In 2002, South Korea recorded 400 new HIV cases, compared to 124 in 1997. HIV spread through needles was considerably less.

Taiwan: Like South Korea, the country has been enjoying impressive economic growth due to its medium and high tech industries. Many of the factors contributing to rapid growth of the epidemic in other Asian countries are present in Taiwan, including thriving commercial sex rackets. There has also been concern about Taiwanese tourists to South-East Asian countries seeking sexual services.

The first AIDS case in Taiwan was a foreigner in transit in December 1984. Out of the approximately 25,000,000 HIV tests done up to September 2003, a total of 5,399 tested positive for HIV, and 1,585 had developed AIDS. Among the persons with HIV in-

fection, 4980 were local people and 419 foreigners. About 41.8 per cent of the local people tested positive were heterosexual, 35.7 per cent male homosexual, 13.1 per cent male bisexual, and 1.36 per cent haemophiliacs. Of the total number of HIV-positive persons, 36 per cent and 33 per cent are in their 20s and 30s respectively. Nearly 93 per cent of the HIV-infected Taiwanese are male.¹⁵

Though Taiwan currently has a low prevalence rate, some health experts predict a bleak future and believe that HIV cases are already two to five times the official figures. The Centre for Disease Control (CDC) here estimates that by 2010 there will be 15,000 people living with the virus. The biggest concern for many health experts is homosexual men with a low rate of condom usage as some studies have shown.¹⁶ The other area of concern is the fact that casual and unsafe sex among youth is rapidly on the rise.

Risk factors

The main risk factors of HIV transmission in the region include high rates of sexually transmitted infections among vulnerable groups, limited medical and counselling services, lack of condom access and use, extensive cross-border travelling, trafficking, lack of political commitment and legal protection against discrimination and deterioration of educational programs targeting the youth.

Women hit: In most countries of the region, men account for a disproportionately large number of those living with HIV/AIDS. However, experience has shown that as the epidemic advances, it is likely that heterosexual sex will increasingly become a predominant mode of transmission. In such a scenario, women are particularly

Coercion against condom

Chronicle Foreign Service¹⁷ reports that woman initiating the issue of HIV with their partners and asking them to use condoms would appear rude. The report quotes Nozomi Mizushima, programme manager of Japan-based Sex Work and Sexual Health (SWASH) in explaining that the low status of women has complicated the group's AIDS prevention work. A recent SWASH survey in Japan showed that nearly 53 per cent of 'massage parlour' workers never ask customers to use condoms even though they are aware of the risks. Some brothel owners have banned condoms to please male costumers and put pressure on female employees not to report acts of violence against them.

vulnerable as in many East Asian societies they are still not expected to discuss or make decisions about sex-related matters. Refusal to have sex or insisting on condom use with their spouses often put them at risk of abuse and suspicion of infidelity. Many poor women enter the sex trade by force or deception or are lured at a time of pressing financial need. There are a large number of women in the region who are migrant workers and their vulnerability to HIV infection is rarely understood or addressed.

Human trafficking: Trafficking of women into the sex industry in Japan has been a significant problem for many years and a matter of great concern lately. For instance, it was noted that traffickers in Thailand promise lucrative jobs to gullible women and trap them in huge debts by the time they arrive in Japan. To repay these exorbitant sums – usually US\$25,000 to US\$40,000 – they must work for months, or even years, without pay, suffering coercion and abuse. Many end up in prostitution involving unsafe sex.¹⁸ Several thousand Filipino women trafficked to Japan also face similar vulnerability to HIV. Gruesome tales of sexual slavery and trafficking in women from

North Korea to China have also been documented.¹⁹

Feverish reactions

State intervention: All countries of East Asia have come up with strategies and policies to tackle the HIV menace, though they widely vary in the levels of political commitment, funding levels as well as interventions. Curative or preventive interventions include surveillance, medical care, testing and counselling services, blood safety measures, professional training and health education. Medical personnel in almost all countries in the region are supposed to report HIV/AIDS cases and deaths involving them to local health authorities within 24 hours.

During their rapid economic development over the past few decades, East Asian countries, especially the 'Tiger economies' could invest substantial amounts in human capital and in the health sector. Right to public health is a fundamental constitutional right in Japan. In 1950, Japan's Social Security Committee offered insurance or public subsidy to ensure minimum livelihood to the poor. Japan's national health insurance covers 70 per cent of AIDS treat-

ment, while the Taiwanese government bears its full cost of around US\$12,000 per month. In Taiwan, the national health insurance scheme of 1995 gave all citizens equal access to health care, covering 96 per cent people. Persons with HIV/AIDS can get free or subsidised drugs in Taiwan, Japan, and Hong Kong. South Korea and Hong Kong have strong public health care systems. However, rising life expectancy, associated with dramatically changing needs of healthcare and price hikes in drugs amid slow economic growth offer new challenges to the system. In Mongolia, health expenditure as a proportion of GDP has decreased over the last ten years from 5.5 per cent in 1990 to 3.3 per cent in 1998.²⁰

In 2001, China's health ministry set up a Centre for Disease Control and Prevention, adopted a five-year action plan, and increased government spending. Observers note that in the past three years Chinese authorities have shown the first clear signs of commitment to fight the disease. There are a growing number of international projects on AIDS in China, perhaps indicating increasing openness on the subject.

Hong Kong has a five-year policy focussed on prevention. The government has identified seven vulnerable communities, namely men who have sex with men, injecting drug users, people with sexually transmitted diseases, cross-border travellers, youth, sex workers and their clients, and people living with HIV/AIDS.

Media attention: Across the region, the media have promoted public awareness about the issue of HIV through advertisements, news and views. For instance, in mid-2002, the Japanese health ministry sponsored the broadcast of a series of 'Stop AIDS' commercials

featuring national soccer star Seigo Narazaki, a 2002 World Cup star. Still, the media attention on the issue, particularly related to stigma and discrimination, has been far from adequate.

NGO action: NGOs, often funded by the government, are gradually reaching out to people. People with HIV/AIDS themselves run a few NGOs in Taiwan and Hong Kong. There are at least eight such groups in Hong Kong, networked for effective collaboration. "This network is believed to have strengthened the NGOs movement on HIV/AIDS," said Loretta Wang of Hong Kong-based AIDS Concern. Jose Chang, a person with HIV, working with Harmony House, a small transitory shelter in Taiwan, says: "About five HIV-related NGOs in Taiwan are focusing on sex education, (mostly telling them about) loyalty among partners, safe sex, etc, and distributing condoms." The movement of people living with HIV/AIDS is vibrant in Taiwan and South Korea as well. However, regional networking is still weak and excludes China and North Korea.

Global Fund: Japan is a founder member of the Global Fund to Fight HIV/AIDS, TB and Malaria. "Japan worked hard to establish the Global Fund," says Deputy Minister for Foreign Affairs, Ichiro Fujisaki. "When the Fund started, Japan, as one of the founders, announced that it would contribute 200 million dollars in the initial 3 years. We are faithfully implementing our commitment..."

According to an AIDS Policy Project release on October 17, 2003, the Global Fund approved China's application for more than \$32 million over two years to fight HIV/AIDS. The AIDS Policy Project expressed in a statement their concern that the country's 'severe cor-

ruption problem' could limit access to the funds,²¹ sharing a fear of civil society groups across the world.

The fund has also approved US\$122.7 million to Mongolia for HIV/AIDS. South Korea has received funds to fight TB and Malaria, but not HIV/AIDS. Taiwan and Hong Kong are not qualified to get this fund. Except Mongolia and North Korea, money is not a main factor in determining availability and access to quality care to people with HIV/AIDS: it has more to do with social attitudes and political commitment.

Wrong targets

HIV/AIDS-related stigma is commonly manifested as discriminatory laws, policies, and administrative procedures often justified as necessary to protect the general public. Taiwan has put in place compulsory screening, testing and notification of AIDS cases, restricting right to anonymity. This leads to exclusion of people with HIV/AIDS from certain occupations and their medical examination, isolation and even detention. Even when a more positive legislation exists, it is not always enforced in other countries. For instance, Japan has a law to protect the rights of people with HIV to education, employment, confidentiality, information, and treatment – but that has not prevented discrimination.

The high investment in health care made by some of the countries came with different price tags. Hong Kong offers subsidised drugs and medical care to all permanent residents with HIV/AIDS, though it counts out other long-term residents. Screening of high-risk groups, military recruits and prison inmates is common in Japan, Hong Kong and Taiwan. In

Taiwan and Mongolia foreign labourers are tested for HIV. In Japan, anonymous tests are carried out at health centres. Taiwan instantly expels foreigners detected positive.

HIV testing without consent, breaking confidentiality, and denial of treatment and care by the medical community are some of the rights issues in the region. A *Taiwan News* survey showed that eight out of 50 people with HIV have suffered discrimination by medical staff while 30 per cent were refused medical care.²² "Human rights have always been neglected, not to mention those of AIDS patients," says Jose Cheng, director of Taiwan's Persons with HIV/AIDS Advocacy Association. "We even have to offer AIDS patients a list of doctors who are kind enough to treat them."

Sex sells: Though legally not permissible, sex industry is booming in many countries, with governments doing very little. In Japan, South Korea, Hong Kong, and Taiwan sex sale is growing in leaps and bounds. Specific inter-

vention programmes for sex workers in the region, like in most parts of the world, focus on HIV/AIDS, rarely addressing broader issues especially poverty, trafficking and criminalisation. Mere education of sex workers and provision of condoms are just not enough to keep the virus at bay.

Wrong lessons: Children born with HIV/AIDS or associated with HIV infected family members are often discriminated against in educational settings in certain coun-

tries in the region. They are sometimes forced by their classmates to show their HIV test reports.

Workplace problems: In many countries, there are practices such as pre-employment screening, denial of jobs and sacking of those who test positive and discrimination against those who do not submit blood reports. There were also reports of workers refusing to work next to colleagues with HIV/AIDS or suspected infection. One of the most urgent tasks to be done

Locomotive logic

In July 2002, MRT, the state-run subway in Taiwan, rejected a new driver after he tested positive for HIV. Subway authorities argued that in case of an accident, he might spread the disease to his passengers.²³

The UK-based Gay Network has reported that a man was offered a job by the Tokyo Metropolitan Police Department in 1997 and part of his preparations included a physical examination, which included a blood test for HIV without his knowledge. A day before training was to start, the authorities told him he was tested positive, asking him to resign. The logic: the tough training and physical stress of a police job could hasten the onset of AIDS. Reportedly, the man eventually got the job this year.

Reported Cases of HIV/AIDS by Exposure Category Taiwan
1984 – October 2003

Exposure Category	HIV(+) *	cH	AIDS	cH	DIE#	%
Heterosexuals	2049	40.64%	789	50.58%	456	50.44%
Homosexuals	1840	36.49%	415	26.60%	208	23.01%
Bisexuals	613	12.16%	260	16.67%	156	17.26%
Haemophiliacs	53	1.05%	19	1.22%	32	3.54%
Injecting Drug Users	100	1.98%	30	1.92%	20	2.21%
Blood recipients	12	0.24%	4	0.26%	7	0.77%
Vertical transmission	9	0.18%	2	0.13%	1	0.11%
Unknown	365	7.24%	40	2.56%	23	2.54%
R/O Wound infection	1	0.02%	1	0.06%	1	0.11%
Total	5042	100.00%	1560	100.00%	904	100.00%

*include people living with AIDS

Source: www.cdc.gov.tw/En/ShowTopicText.ASP?TopicID=135

Fast-track routes

HIV is a snowballing crisis in China. The most populous country in the world has only about 20,000 registered HIV cases, but estimates of adults and children living with HIV/AIDS varied between 500,000,¹ 600,000^{2,3} and one million⁴ by 2000 end. After the first detected case in 1985 and a slow rise between 1990 and 1993 with fewer than 500 new cases a year, it has been an exponential growth. The projected figure of 10,000 in 1993 grew ten-fold to 100,000 by 1995, and possibly another ten-fold by 2000. Yet another ten-fold rise to 10 million is feared in the coming five years,⁵ or in 10 years as optimists say.^{6,7}

Changing sexual behaviour, increasing injecting drug use and a thriving sex industry employing 10 million women⁸ suggest that the doomsayers could be more right. Besides, the HIV-1 subtypes evolving in the region are capable of fast-track spread. A few more grim strokes are added to an already dark picture by discrimination against people with HIV/AIDS and a lack of good education on AIDS and safe sex.⁹ Sometimes authorities simply black out the problem, as if it never existed. At the same time, high rates of HIV prevalence among commercial blood donors¹⁰ offer a red alert for safe medical equipment and biohazard guidelines.

In a sexually transmitted infection (STI) prevalence survey by the National Centre for STD and Leprosy Control among 505 female sex workers and 550 male truck drivers, 25 per cent of the sex workers had co-infection with both gonorrhoea and chlamydiosis; 10 per cent were positive for HIV. The highest prevalence of chlamydial infection or gonorrhoea was observed among the 15–19 and the 19–24 age groups.¹¹

The Chinese Long and Medium Term Plan for Preventing and Controlling the Spread of HIV/AIDS (1998–2010) (State Council Document 1998–38) observed that the 'very rapid spread of HIV among

intravenous drug users has still not been brought under control. The transmission of HIV through the collection or transfusion of blood has still not been stopped. Illegal manual blood plasma collection methods along with the illegal collection of blood plasma have still not stopped despite repeated prohibitions."

Increasing vulnerability : An increase in the rate of sexually transmitted infections (STIs) in a community usually indicates changing sexual mores and/or a deficit in public health settings. A more than 100-fold increase in the reporting of STIs in the last 13 years, better acceptance of premarital and extramarital sex, more sex workers and rising migration are all factors that will hasten the HIV spread in China.¹² Between 1990 and 1998, 4.2 times more women and 3.8 times more men contracted venereal diseases and syphilis increased by about 20 times, a growing source being extramarital sex.¹³

In Yunnan province the male to female rate of infection has dropped from 20:1 in 1989 to 3:1 in 1998. The two main routes of transmission are injecting drug use (73%) and sexual (13.6%). The reported prevalence on HIV infection is 24.4 per cent in IDUs, 2.4 per cent among sex workers, 1.6 per cent in STI patients and 0.2 per cent among women attending antenatal clinics. The calculated prevalence rate for 1998 in the 15–49 age group was 0.15 per cent.¹⁴

Studies presented at the XIII International AIDS Conference in Durban, South Africa (9–14 July, 2000) showed IDUs had the highest HIV prevalence (up to 82%).¹⁵ While 0.23 per cent of the inmates at a Shanghai prison have been reported positive,¹⁶ various sentinel surveillance studies in pregnant women in Xinjiang report prevalence between 0.38 to per cent.¹⁷ The data suggest that the virus is changing route from IDU to sex and moving faster.

Grim projections: With the trend from 1997 to 1999, we can calculate the proportional increase (PI) of the HIV epidemic during this period. Since many factors influence this trend, and there are many conditions that are contributing to the apparent general low prevalence such as rapid population movement, under-reporting, urban-rural variations in HIV reporting, tough and confidential access to HIV testing, changing cultural patterns, increasing high risk behaviours and weak preventive efforts,^{18, 19, 20} a correction factor should be used to make the projection more realistic.

To have an accurate projection, more sentinel surveillance, as well as social and behavioural studies are needed. These need to be focused not only on ‘high prevalence groups’, but also on the general population in which risk behaviours are known to be increasing. New methods for monitoring and surveillance of HIV/AIDS have to be developed for this part of the world. We need

to understand the influence that the current “cultural opening” will have on the expansion.

With an unusual candidness, Gao Qiang, executive vice minister of health told the HIV/AIDS High-level Meeting of the UN General Assembly on 22 September 2003: “China is a developing country with large income gaps among the regions. In particular, the economic and social development in rural areas is still at an early stage. Criminal offences like smuggling, drug trafficking and prostitution have not been eliminated. In some areas, HIV/AIDS prevention and treatment have not been adequately attended and funded. Therefore, HIV/AIDS in China has not been effectively controlled.”

However, it appears that the Chinese government is beginning to provide some space for emerging community groups such as China AIDS Network (CAN) to focus on the social and behavioural dimensions of AIDS.

Projections for China and East Asia and Pacific

Country	Prev 2001	Pop 2001	PLWH/A 2001	Prev 2003	Pop 2003	PLWH/A 2003	Prev 2005	Pop 2005	PLWH/A 2005
China	0.20	1,286.408	2,531.652	0.48	1,306.991	6,327.509	1.19	1,327.903	15,814.723
Total EA & Pac	0.20	1,503.596	2,983.135	0.49	1,529.970	7,527.940	1.22	1,556.805	18,996.750

Prev: prevalence (%). Pop: population in thousands. Proportional increase
 Natural population increase (annual %)
 PLWH/A: People living with HIV/AIDS (Children and Adults)

1. Shao Y (2000), Deputy Director, National Centre for AIDS Prevention and Control. *The HIV/AIDS Pandemic: South and Southeast Asia Standing on the Precipice*. American Foundation for AIDS Research, (amfAR). Symposium: World AIDS Day 2000, Nov. 30, New York
2. IHT (2000a) For the Record, IHT June 15
3. IHT (2000b), In China, ‘Denial of AIDS Reality’. *International Herald Tribune*, August 3
4. BBC (2000), AIDS spreads in China. BBC News, Asia-Pacific, August, 14
5. *ibid.*

6. Ammann AJ (2000), Global strategies for HIV prevention, a generation free from HIV. China Visit Report, August.
7. Tomlinson R (1998), China Recognizes AIDS problem. *BMJ*;316:493
8. BBC (2000)
9. Su L, Du F (1998), HIV infection and AIDS in China. *Am J Public Health*;88:307
10. Zheng X, Yan J, Zhang X (2000). The survey of prevalence of HIV infection among paid blood donors in one county in China. The XIII International AIDS Conference, Durban, South Africa.

11. World Health Organization Regional Office for the Western Pacific, National Centre for STD and Leprosy Control, Ministry of Health Of the People's Republic of China. STI/HIV Prevalence survey of sexually transmitted infections among female sex workers and Truck drivers in China 1999–2000
12. Xu H, Zhang J, Anderson FA, Xu X, Chu T (2000). Heterosexual transmission may become HIV main transmission mode in China. The XIII International AIDS Conference 2000, Durban, South Africa
13. Chen X-S, Gong X-D, Liang G-J, Zhang G-C (2000). Epidemiological trends of sexually transmitted diseases in China. *Sexually Transmitted Diseases* ;27:138–142
14. Zhang J (2000). Ten years of experience on AIDS control in Yunnan (1989-1998). The XIII International AIDS Conference 2000, Durban, South Africa
15. Qu S, Sun X, Zheng X. National sentinel surveillance of HIV infection in China from 1995 to 1998. The XIII

International AIDS Conference 2000, Durban, South Africa

16. Bao J. Analysis of 30 cases infected with HIV in Shanghai prison system. The XIII International AIDS Conference 2000, Durban, South Africa
17. Zhang Y, Sun F, Zhou M, Wang D, Jiang Y, Brooks Jackson J, Shan H, Shao Y. HIV testing among pregnant women in Xinjiang, China. The XIII International AIDS Conference 2000, Durban, South Africa
18. Liu M, Meyer M. Facing (2000), a Demon: once indifferent about AIDS, China starts to confront a looming crisis. *Newsweek International*, December 1
19. BBC (2003)
20. Cock KM, Weiss HA. The global epidemiology of HIV/AIDS. *Tropical Medicine and International Health* 2000;5(7):A3–9

Reference

China's Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2001–2005). State Council Office Document 2001–40. Ministry of Health Communicable Disease Control Division. 25 June 2001

in East Asian countries is public education backed up by laws.

In East Asia, as in other parts of the globe, people with HIV/AIDS as well as their carers and supporters are often blamed and isolated. At Hong Kong's New Kowloon Bay, when a new primary health centre was opened, professionals working with PLWHA were harassed and discriminated by local residents, reports Hong Kong Coalition of AIDS Services Organisations. Despite complaints, a small group of local residents blocked their access to the clinic and harassed them. They erected signs vilifying people living with HIV and other disabilities – a clear violation of the Disabilities Discrimination Ordinance.²³

In East Asia there is a need for better understanding of HIV/AIDS, the modes of transmission and people vulnerable to it and infected by it.

Key recommendations:

- i) Discourage compulsory screening for those perceived to be



HIV/AIDS poster distribution at Suai market, Indonesia

- high-risk groups. Ban mandatory blood test among military recruits, prison inmates and foreign labourers. Human rights and civic groups should protest such practices.
- ii) Legislate to protect the rights of people living with HIV/AIDS as well as vulnerable groups.

- iii) Regulate and monitor the sex industry and check trafficking in people. Governments should act on the social costs of this practice.
- iv) Ensure political commitment and allot enough funds to fight the menace.

Endnotes

1. The paper is based on both primary and secondary sources. Besides secondary sources, key informant interviews were conducted for information in Hong Kong, Mongolia, Japan, and Taiwan

2. Joint United Nations Program on HIV/AIDS, Centre for Disease Control, Taiwan

3. Adapted from: Joint United Nations Program on HIV/AIDS, Centre for Disease Control, Taiwan

4. Thursday Aug 7, 2003, South China Morning Post, "HIV Treatment - The Perils of the mainland's free AIDS-drug policy" Drew Thompson

5. Agence France Presse 11/6/03, China News Service

6. HIV / AIDS in China Spreads Into the General Population Population Reference Bureau, 30/04/03

7. Special Preventive Programme, Department of Health, Hong Kong. August 12, 2003

8. "Japan Only Now Confronting Rising HIV Rate", Suvendrini Kakuchi, *San Francisco Chronicle* 03.17.03

9. WHO report on HIV/AIDS in Asia and the Pacific Region

10. "Young People Account for 40 Percent of HIV-Infected in Japan" Kozo Mizoguchi *Associated Press* 08.06.02;

11. UNAIDS in the Epidemiological Fact Sheet – 2002 Update

12. www.un-mongolia.mn/unicef/health.htm

13. (www.youandaids.org; HIV/AIDS Portal for Asia Pacific

14. Changing Attitude Toward Sex Threatens South Korea *San Francisco Chronicle* 14/03/03

15. "AIDS Control In Taiwan", Centre for Disease Control, Department of Health, Taiwan 2000

16. "AIDS IN ASIA: The Continent's Growing Crisis: Prosperous Taiwan fights HIV with education: Free condoms in gay gathering places to keep infection rate low" Nelson Wang, *Chronicle Foreign Service, San Francisco Chronicle* – March 1, 2003

17. "Japan only now confronting rising HIV rate: Women in sex trade most at risk" Suvendrini Kakuchi, *San Francisco Chronicle* - Monday, March 17, 2003

18. "Owed Justice: Thai Women Trafficked into Debt Bondage in

Japan" Human Rights Watch's September 2000 report

19. "The Invisible Exodus: North Koreans in the People's Republic of China", Human Rights Watch Report November 2002

20. www.un-mongolia.mn/mongolia/general.htm

21. www.thebody.com/kaiser/2003/oct17_03/global_aids.html

22. "HIV carriers need legal protection, activists say," *Taiwan News*, October 21, 1999

23. www.ilga.org/Information/Legal_survey/Asia_Pacific

References

www.api-net.jfap.or.jp
www.info.gov.hk/aids
www.utopia-asia.com/aidskor.htm
www.wpro.who.int/pdf/sti/aids2001/
www.thebody.com/whatis/demo_japan.html
www.japanetwork.org
www.unaids.org
www.hivaidssearch.com
www.census.gov/ipc/hiv/taiwan
www.cdc.gov.tw
www.ilga.org
www.un-mongolia.mn





Combat against terror

Tigers and neighbours find the virus invincible; calculations go wrong

...if adequate measures are not taken urgently, the region might see yet another financial crisis and in turn a massive development crisis. That is, the virus can be yet another security threat

South-East Asia, home to over 538 million people, comprises 11 countries with stark contrasts in social and economic terms. While 'Asian Tigers' like Singapore and Malaysia can flex their economic muscle, poverty is still widespread in countries such as Myanmar (Burma), Timor-Leste (East Timor), and Laos. At least 100 million people live below the poverty line in the region, as Red Cross figures note.

Health and education systems in many countries of the region have not fully recovered from the 1997 economic crisis. The major economic players, the Association of South East Asian Nations (ASEAN) members, including the 'Tigers' of the region, are engaged of late in the post 9/11 global fight against terrorism, while striving to boost international trade. US-ASEAN and EU-ASEAN joint declaration on combating terrorism attracts a lot of attention and resources while a burning issue like HIV/AIDS remains rather invisible, like the virus that causes it.

There is indeed a joint initiative of ASEAN members to fight

HIV/AIDS, but the fight is largely on the drawing board. This region, one of the world's leading recipients of foreign direct investment, with five of its states among the top twenty capital magnets worldwide,¹ still finds it difficult to provide care and support and anti-retroviral (ARV) therapy to many of its citizens. The trade-savvy region has somehow failed to value the lives and health of its citizens exposed to HIV/AIDS.

Activists involved in the HIV/AIDS issue hope that the ASEAN commitment will be translated into action. They warn that if adequate measures are not taken urgently, the region might see yet another financial crisis and in turn a massive development crisis. That is, the virus can be yet another security threat.

The emerging virus

Though many South-East Asian countries have taken HIV/AIDS as a health issue, health is not a priority in the region. In many countries like Cambodia, Myanmar (Burma) and Laos, the public health care system does not

No hurry for aid

Timor-Leste (East Timor) health minister Dr Rui Maria de Araujo, a medical doctor, says fighting HIV/AIDS is a social responsibility of the state

How bad is the HIV/AIDS scenario in East Timor?

I think the situation of HIV/AIDS in East Timor is different from that in other countries. Though out of 800,000 people, only four were found positive, there are other factors that have contributed to a situation of vulnerability here. After the crisis in 1999 [when militia loyal to Indonesia tried in vain to use terror to discourage a vote for independence], poverty is rampant. The number of homeless people is high, the international community is spread throughout the country and prostitution is growing. The government is aware of these factors and preparing an effective strategy for timely response.

But others, including international humanitarian agencies, say HIV/AIDS is not a priority in East Timor?

It depends how you define priority. If you see priority as something that is important, something that is threatening the country, then HIV is one of the priorities. In East Timor we have a window of opportunity to prevent an epidemic because of the low prevalence and we have the opportunity to work hard to strengthen the public health care system.

How does health in general and HIV/AIDS in particular figure in East Timor's political vision?

Health is the second highest priority for the government. The political leadership look at HIV/AIDS

as one of the biggest threats to development. We want to prevent the disease before it threatens the existence of the people and it is the social responsibility of the state.

Is it true that East Timor has only 24 doctors?

Yes! You are right; there are few doctors but at the same time we want to see the public health system should not be 100 per cent dependent on doctors. We focus on strengthening the capacity of local public health workers, the backbone of the health system.

What is unique about East Timor's way of addressing HIV/AIDS?

One of the unique features is that we try to engage local infrastructure at community and government levels as much as possible. Another feature, I think also a challenge, is to work with the Catholic Church. Because the majority of the population is Catholic that may be challenge, but uniqueness would be in finding a common goal and a good working relationship.

What role do you see for international humanitarian groups?

I think international development organisations have an important role to play in supporting our civil society organisations. We want our civil society to be strong... and stand up as a good partner of the government.

What about financial support?

My request to the international community is not to be in a hurry to put money in East Timor. Yes we do need money, but we also need to build up the capacity to handle the resources.



have the capacity to provide care and support to the patients. Richer countries like Malaysia, which have a sound health care system, do not address HIV/AIDS components such as counselling services. Singapore, the topper in the GNP per capita count, does not subsidise anti-retroviral treatment. Thailand is trying to address the

issue from a public health perspective by providing health care to sex workers and others in dire need. In the not-so-rich countries like Cambodia and Myanmar (Burma) the situation is rather unhealthy. Vietnam is busy dismantling government health care services, thereby making its increasing number of poor people vulnerable to HIV.

In the context of economic globalisation, people's mobility and patterns of migration change drastically, dictated by shifting priorities of a market economy. Socio-political conflicts, economic disparity, social injustice and power dynamics in different forms have indeed created a critical situation for migrants – making a set of

people more vulnerable to the virus. There is mandatory HIV/AIDS testing for migrants and pregnancy tests for migrant women in some of the countries in clear violation of human rights.

Time has come for Cambodia, Laos and the Philippines to take effective and timely action. In a region where sex trade is condoned as an unavoidable component of 'development', there is a rush to catch up with the 'illustrious leader' in the trade like Thailand. In the process, hundreds of thousands of girls and women are becoming extremely vulnerable to HIV/AIDS.

Losing teeth

People displaced by development interventions, conflicts and disasters and migrating in search of livelihood opportunities within and outside national borders are also the groups highly vulnerable to HIV/AIDS. These dispossessed, displaced and disempowered people also happen to be the ones who can least afford to deal with HIV/AIDS economically. In Thailand's Chiang Mai province, families with HIV/AIDS-affected persons were reportedly spending on an average, US\$1,000 in medical costs, an amount equivalent to half the average annual household income, as the study by Pitayanon *et al* shows. In rural parts of Cambodia, the high costs of medicine and the rural credit system combine to make HIV/AIDS a significant cause of landlessness, says a 2002 paper by UN Economic and Social Commission for Asia and the Pacific (ESCAP).

The 1997 economic crisis in the South-East Asian countries has left long-term effects in different sectors. The recovery was generally much faster in 2002 than anticipated earlier in the year. Indeed,

GDP growth at 4.1 per cent in 2002 was about one per cent above what was predicted in Malaysia and Thailand. To some extent, the Philippines showed a strong recovery trend while Singapore moved out of recession. The economies of Indonesia, Laos, and Vietnam improved only marginally from the 2001 levels. In contrast, GDP growth fell from 6.3 per cent in 2001 to 4.5 per cent in Cambodia, one of the poorest countries, as Asian Development Bank (ADB) figures show. There are clear signs of recovery in all countries, but the crisis has seriously affected public health care system in the region.

The impacts are very clear. In the Philippines, there have been budget shortfalls and funding delays for a range of health programmes and services, including HIV control and maternal and child services. In Thailand, there were substantial cuts in reproductive health programmes during 1997–98. The HIV/AIDS budget was reduced by 24.7 per cent in 1998. Says Dr Manit Teeratantikanont, deputy director general in the disease control department of the Thai health ministry: "The Thai Government is acutely aware of the need to stay on top of the AIDS situation. As soon as we discovered the first HIV cases we realised that it could not only turn into a huge health problem but also have a serious impact on society and the economy.

In Indonesia, there has been no discernible effect on reproductive health programmes, but the HIV/AIDS budget was cut by half in 1999. There was an overall reduction in public health care funding by six per cent. In Vietnam, there has been a 10 per cent drop in the provincial government's per capita health budgets in 1998 but no substantial effects were detected on

reproductive or child health programmes. Immunisation coverage is stable and very high by regional standards. In Laos, there are few data on programme coverage. Immunisation coverage rates, already low, declined slightly in 1998; however, the reasons are not clear and it is too soon to conclude that this was related to the economic crisis as Macfarlane Burnet Centre for Medical Research shows.

In Indonesia, the nominal health budget for the 1998–99 fiscal year was cut by four per cent from its 1997 level. In real terms, the cut was much higher owing to rising inflation, as ESCAP figures show. Accordingly, the health expenditures of the Government of Thailand had been rising until 1997, when the crisis forced government to trim the 1998 national budget by 17 per cent. The Ministry of Public Health cut its budget for HIV/AIDS related work by 24.7 per cent in 1998, compared with a 5.5 per cent cut in the rest of the health budget.

The Cambodian public health system is weak and not accessible to most poor families, with one of the worst rates of utilisation of health services in the world. On an average, a Cambodian has only 0.35 medical contacts with organised health services within a year, Cambodia Socio-Economic Survey (CSEC) shows. Government expenditure on health is placed at \$1 per capita.² Public hospitals and clinics are often decrepit and poorly kept.

The virus trail

Cambodia: Out of the total population of 13 million, Cambodia has an estimated 157,500 people living with HIV/AIDS, according to the National Centre for HIV/AIDS, Dermatology and Sexually Transmitted Diseases statistics.

Politics of a virus

Satur C Ocampo, president of the political party Bayan Muna (People First) and member of the congressional committee on health in the Philippines, says HIV/AIDS is a political issue.

How is the Philippines combating HIV/AIDS?

We have been relatively successful on certain fronts; for example, we succeeded in developing a public information campaign. One of the highlights is the involvement of HIV positive people, who were brave enough to come forward and be the torch-bearers. However, the increasing number of infected people is a concern.

The Philippines has fought colonisers, autocrats and the military, and health workers have played a crucial role in these struggles. Any useful lesson for the current combat?

During our struggle against colonisers and autocrats, health workers, human rights activists and popular movements found it necessary to work together. Their sense of commitment was very crucial. They worked often outside the government system. It was this synergy and joint work that made the people listen and work together. HIV/ AIDS is not just a health issue and we need to find ways to address it decisively.

The World Development Report (2004) says that privatisation may not be the answer for developing countries. Is this not a U-turn?

The negative fallouts of the IMF and World Bank policies are well evident and are increasing. This



single factor cannot be ignored by any leader. So this development makes it all the more important to amplify our voices and struggle. The economic reforms should deal with the realities. It means reversal of privatisation. Government leaders know this, and they are coming under pressure from people's movements. The current trend of declining health budgets in the Philippines must be reversed if we need to combat HIV/AIDS.

Is HIV/AIDS an important political issue in the Philippines?

Yes, it is. It is attaining a more political nature.

Some US policymakers see HIV/AIDS as a 'security issue'. Would this necessitate a security response?

Well, armed forces have a definite role to play, especially the armed medical corps. The point is to address the issue in a holistic way, mainly by strengthening the public health system and democracy.

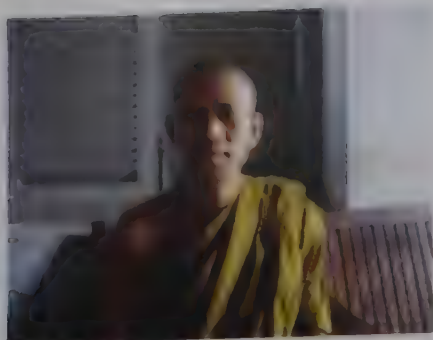
In the Philippines, people, especially the women's groups, are opposing ongoing joint military exercises and new bilateral military pacts with the US that will ensure the presence of US forces here for the next five years. Historically, US military bases have been breeding grounds for social diseases and sexually transmitted diseases. We need to immediately check and block the increasing influx of US military forces into our country.

In the Asia-Pacific region, Cambodia had one of the highest estimated annual mortality rates from all causes in the total 15–49 year old population, about 6–7 per 1000 per year. For a nation still trying to recover from decades of colonial rule, foreign occupation and civil war, HIV/AIDS poses a serious threat. Cambodia is the worst affected country in the region, with

clinical case burden of HIV/AIDS-related diseases and conditions being most severe here, as a 2001 WHO update on HIV/AIDS in Asia and Pacific Region warns.

Myanmar (Burma): Myanmar faces one of the worst HIV problems in Asia. According to one controversial estimate, 3.46 per cent of the adult population – some 687,000 people – is infected with

HIV, a figure the government hotly disputes.³ UNAIDS estimated 400,000 people infected by HIV by the end of 2001 – just under one per cent of those aged 15–49.⁴ HIV prevalence among sex workers tested in Yangaon and Mandalaya has increased from a median of four per cent in 1992 to 26 per cent by 1997. Based on an HIV prevalence estimate of about 500,000 in



Tieng Vutho vice-chief of Monks, Sray Propei Pagoda, Cambodia

the year 2000, the annual number of adult AIDS cases in Myanmar was calculated by UNAIDS to be 46,600 in the year 2000 and is projected to reach over 55,000 in 2005, WHO warns.

The Government had been in a dilemma whether or not to call HIV/AIDS a 'major problem' till 2001. Still it is ambivalent about the issue. Health Minister Major General Ket Sein, told a WHO meeting earlier this month: "Contrary to the gloomy picture presented in some reports in the western media, HIV/AIDS is not rampant in Myanmar." However, reporting the same event, the BBC quoted Lt General Khin Nyunt's statement to the *Myanmar Times*: "HIV/AIDS is a national cause. If we ignore it, it will destroy the entire race."⁵ Says UNAIDS country coordinator, Eamon Murphy: "There is a strong need to recognise HIV/AIDS as a humanitarian concern by the government, international agencies and political parties in Myanmar."

Thailand: The HIV/AIDS situation in Thailand is closely monitored and projected for public health and health care planning by a national expert group. The Thai working Group on HIV/AIDS projection shows 695,000 people are currently living with HIV/AIDS. Each year up until the end of 2006, over 50,000 Thais may die from AIDS-related causes. Thailand's 100 per cent condom promotion among sex workers is a successful

story. However, the government has not had much success in reducing HIV prevalence among the injecting drug user population.

Malaysia: Malaysia has a predominantly market economy, with the GNP per capita, the third highest in the region, after Singapore and Brunei. Malaysia is a country with HIV concentrated among its IDUs. In 2000, about 42,000 people were HIV positive. The annual number of AIDS deaths is around 2,400. It is projected that annual number of AIDS deaths will be over 6,000 in 2005. The vast majority of these deaths will be among young (25–39 year old) males, going by WHO statistics.

Vietnam: Vietnam has a centrally planned developing economy that is largely based on agriculture. Vietnam health ministry reported 1,299 HIV cases in the first half of 2003 taking the total number of infected to 67,100. The country now has 10,200 AIDS cases, and more than 5,700 people have already died from the disease.⁶ The actual figure is estimated to be more than 200,000.

The most advanced HIV epidemic started among older male IDUs in the cities of south and central Vietnam. A new group of younger men in the southern provinces are starting to inject heroin after beginning use by smoking or snorting it. There are also some female sex workers beginning to inject heroin.

A second and more recent HIV epidemic is among young male IDUs who live along the main heroin trafficking routes and in cities in the far north of the country and in Red River Delta. As of 31 May 2001, IDUs accounted for about 61 per cent of cumulative numbers of reported HIV infection. Close to 4,000 AIDS deaths were

estimated in 2000, and by 2005 there will be around 11,000, experts project.

HIV/AIDS as a serious issue is being recognised at the highest level of the government and the ruling party. However, that recognition has yet to percolate down to provincial and local level administration. Vietnam lacks leadership at different levels to play a vital role by recognising the rights of people with HIV/AIDS and to take steps to honour them. As UNDP resident representative Jordan Ryan observes: "In Vietnam, there is a leadership gap, organisational gap and a knowledge gap. If there would be a strong political will and commitment, money is not the problem; donors are dying to give money. But I am hopeful that Vietnam has enough experience to deal with (a) difficult situation."

Singapore: The city state of Singapore is the richest and most capable of addressing any health issue with the same clinical precision as it has been addressing economic issues. Singapore has a low HIV prevalence with about one per cent of patients with sexually transmitted and 0.002 per cent among blood donors infected. In 2000, about 3,500 were HIV positive.⁷ The Singapore government can at times get moralistic and firmly impose its views. A health ministry document noted: "The Ministry would like to emphasize that the only way to avoid AIDS is to remain faithful to one's spouse and to avoid casual sex and sex with prostitutes. A HIV infected person looks and feels normal during the early stage of the infection. It is therefore not possible to tell if a person is infected or not by looking at his/her appearance."⁸

'Urgent Action Needed'

First-hand account of the photographer who took the cover photos of this report

I first visited Battambang provincial hospital in northern Cambodia during the civil war in 1994. Then Khmer Rouge guerrillas and government forces were fighting nearby. The hospital was filled with war casualties and landmine victims. Those were grim times.

The civil war ended in 1998, after killing 1.7 million people. In this new era of peace, Cambodia is at war again, with a new, invisible enemy – HIV/AIDS.

In 2001 I returned to Battambang hospital and began to document the ravages of HIV/AIDS in Cambodia. My most recent documentary work, 'Urgent Action Needed' is an offering of these images, recorded over the past two years.

I took a new approach, requesting the people with HIV and public health staff caring for them to include their personal messages. I wanted to give a voice to those who are often only seen – but not heard.

Because of the social stigma attached to people with HIV/AIDS, and the painful shame that they are made to bear, the patients and their families avoid naming the illness. The lack of information about HIV/AIDS among poorly-educated Cambodians also means that many patients and their families may not know what HIV/AIDS is, how it is transmitted, or what its effects are. They may simply describe it as a "chest infection" or "lack of appetite and loss of strength".

Others may be "hiding" the reality out of fear.

But there is space for a liberal discourse. Says Tony Lisle, team leader of UNAIDS South East Asia Pacific Inter-Country Team (SEPICT): "Singapore government is trying to open up the discourse of sexuality, including the rights of gay people and the government is gradually taking its pace in addressing HIV/AIDS

effectively with a sense of responsibility."

Indonesia: With 212 million people, about 55 per cent of them in the reproductive age group, Indonesia is estimated to have 80,000 to 120,000 HIV positive people, going by 2000 data. It has concentrated HIV epidemics, primarily among IDUs. With a large migrant

population, the situation in Indonesia needs to be monitored carefully, experts feel.

The Philippines: The Philippines has an estimated population of over 80 million, with 48 per cent of them in the reproductive age group. No significant transmission of HIV has yet been detected in the Philippines and as a result the



MASARU GOTO

An SOS message from Cambodia

That is why the diary passages of the patients in this documentary may not openly refer to AIDS.

The medical staffs work under very difficult circumstances. Even basic medical supplies are in short supply. It hurts them to watch helplessly while trying to do their best.

In many cases, when the patients shared these messages, they could still stand up. When I came back to see them, many had died.

A Japanese national, Masaru Goto has spent the past 13 years in South-East Asia and South America, documenting the lives of people caught in conflicts, poverty and oppression.

official national HIV prevalence estimate has been reduced from an initial 50,000 to 26,000 and most recently to about 10,000, says the 2001 WHO update. But experts like Lee Nah Hsu, South-East Asia HIV/AIDS and development programme manager of UNDP think the actual number can be more than what seems. "The Philippines has a passive surveillance system and is currently reviewing its system with assistance from UNAIDS," says Lee Nah Hsu. It can be a serious lack of strategic vision for socio-economic development of the country in the upcoming days, experts note. At the same time experts working in the field caution that the myth of low infection can be a potential threat.

Brunei Darussalam: Brunei with an estimated population of 321,000 has 521 HIV positive individuals and majority of them immigrant workers. By the end of 2000, 16 AIDS cases had been reported, notes the 2001 WHO update. "Countries like Singapore and Brunei with sound economic status despite their low prevalence ratio should be careful. As the major economic players of South-East Asia, both the countries have frequent mobile populations, so there is a strong need to respond to the issue, keeping in mind the concerns of the rights of migrant workers and people living with HIV/AIDS," says Lisle.

Laos: Laos, a landlocked country with so-called 'low prevalence' status is often pointed out as a successful case of limited HIV/AIDS spread. From 1990 to December 2000, a total of 61,130 persons were screened for HIV infection, 717 were found to be positive and 190 AIDS cases reported, including 72 deaths. The majority of the identified HIV infections were in persons with clinical illness, suspected

of having acquired their infection abroad through heterosexual intercourse. Injecting drug use is believed to be rare or non-existent, but no studies have been conducted to confirm this impression, points out UNAIDS 2002 update.

People working in the field of HIV/AIDS in Laos express scepticism about the available figures, arguing that the surveillance system could not cover all provinces, and the actual number could be different. Laos has been trying to open its doors for global economy, and it may have serious impact on HIV spread, especially due to migrant and mobile populations. Preventive measures need to be developed before the epidemic engulfs the population. "But the important aspect is that government has shown its commitment," said Jun Yoshida, UNDP programme analyst on HIV/AIDS and gender.

Timor-Leste (East Timor): Timor-Leste (East Timor), the newly independent state, lacks basic economic resources even to run the primary phase of its HIV/AIDS programme, despite the fact that Government is willing to launch it in a big way. There is no surveillance system and people are making general assumptions and avoiding attention in Timor-Leste (East Timor), as experts note. "East Timor offers an opportunity to address HIV/AIDS before it becomes a calamity, but unfortunately sometimes it seems even the

international community is waiting for a calamity," says Joe Thomas, an HIV/AIDS activist from Timor-Leste (East Timor), who was the former HIV/AIDS advisor to the Health Ministry.

As the global attention is focused on conflicts in Iraq, Afghanistan and the Middle-east, Timor-Leste (East Timor) remains in oblivion. "The East Timor Government is quite positive to develop its health system and initiate HIV/AIDS related programme. Unfortunately they have very limited resources even to initiate the beginning steps," observes Lee Nah Hsu. As Timor-Leste (East Timor) health minister Dr Rui Maria de Araujo notes: "We are strategically and effectively using whatever is available at present and we are hopeful we will make a difference and will be able to address the epidemic in time."

Looking at the overall scenario of SEA, the myth of low infection can be a potential threat for the region, that may lead to a complacent attitude about HIV and a potential catastrophe. At the same time, looking at the socio-economic and existential concerns of the people, time has come for the ASEAN member states to rethink and translate the commitments into practices. "HIV should be viewed as a major threat towards the development of the region and HIV should be addressed in a holistic way. It should be in each

On 9 November 2002, the High Court in Malaysia awarded a sum of approximately US\$130,000 to an eight-year-old boy who was born HIV-infected as a result of his mother having received a transfusion of HIV-tainted blood while pregnant. Mohd Hanis's mother died five years after the transfusion. The child and his father sued the hospital director and the government for negligence in supplying blood not certified as free of HIV. The defendants admitted liability.⁹

of the countries development agenda," says Dr Arauja.

A matter of rights

HIV/AIDS is seen largely as a health issue in the region, however the recent introduction of a set of laws in the Philippines and Cambodia are good examples of securing the rights of people living with it. Vietnam is also seeking legal means to prevent and fight HIV/AIDS. An ordinance is on the anvil. Says Nancy Fee, UNAIDS country coordinator Vietnam: "Stigma and discrimination against people with HIV/AIDS labelling are quite widespread in Vietnam, and the government recognises this." Christopher Herink of World Vision offers a sociological rationale for the legal move: "The concept of HIV/AIDS, drug users and sex workers as social evil has become one of the most critical challenge for Vietnam to fight against."

Significantly, several citizens have recently won legal battles to secure their rights to treatment and a dignified life. Thai positive people won a lawsuit against the pharmaceutical giant Bristol Myers-Squibb. A Malaysian family won a compensation suit in the High Court after getting the infection through tainted blood. It is time for each of the South-East Asian countries to develop effective legislative measures.

As for the Philippines, there is a strong need to realise the sensitivity of the issue by both state and non-state stakeholders. "Proper implementation of the AIDS law promulgated in 1998 remains to be seen. Still stigma and discrimination persists," says Dr Jose Narciso Melchor C, executive director of AIDS Foundation, Philippines.

Thai people living with HIV/AIDS made legal history on 1 October 2002, when they won a lawsuit against the pharmaceutical giant Bristol Myers-Squibb (BMS). The plaintiffs, two people living with HIV/AIDS and a local NGO, the AIDS Access Foundation, lodged a complaint against BMS and Thailand's Department of Intellectual Property (DIP) in Thailand's Central Intellectual Property and International Trade Court (CIPITC).

They claimed that the BMS patent registration for its buffered tablet formulation of the antiretroviral AIDS drug, dydeoxy purine nucleoside (ddl, brand name Videx®), was illegally amended in an attempt to claim a wider monopoly than the patent description justified.¹⁰

Government, international NGOs, NGOs, and the legal system itself have initiated a lot of changes in the region. "The challenge for all of us is to ensure whether we have become able to protect the rights of people living with HIV/AIDS or not," says Sheng Sopheap of HIV/AIDS Coordinating Committee, Cambodia.

Varona, executive director of Asian Migrant Centre, Bangkok: "We are against mandatory testing. We are trying to influence some of the governments in the region to develop policies respecting and recognising the rights of migrant workers."

Large population movements through labour migration, trafficking of people, and displacement due to conflicts, political/economic factors and natural disasters contribute to the spread of HIV epidemic.¹² Overseas mobile workers account for 26 per cent of the reported cases in the Philippines AIDS registry.

Government has not given much priority to health; defence is the most prioritised issue

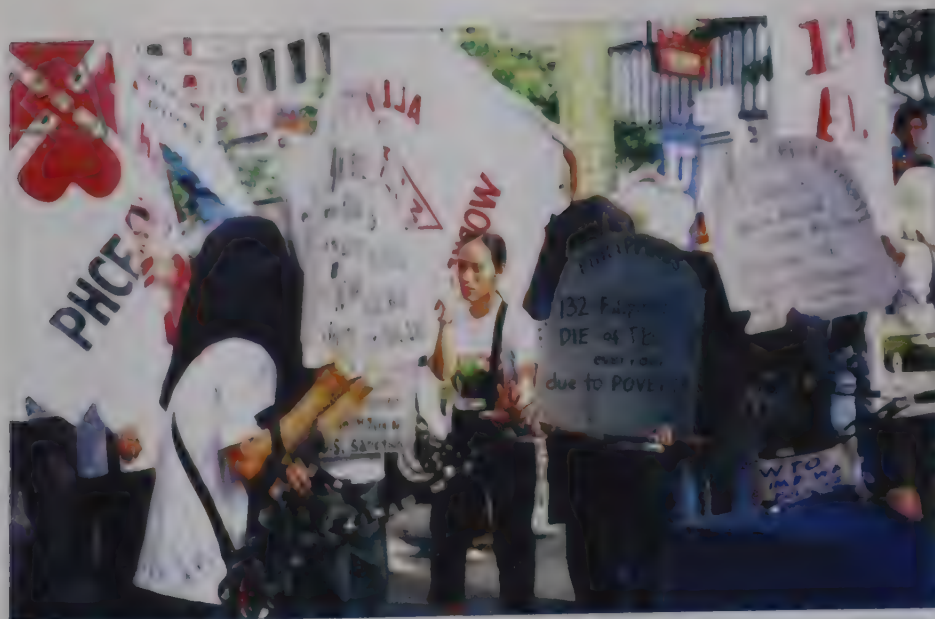
– Dr Jose Narciso Melchor C, executive director of AIDS Foundation, Philippines

Services denied for migrants

Sharp economic disparities within the region lead to large-scale cross-border migration. Thailand, for instance, is a hub of regional migration with an estimated 2.5 million migrant workers coming mainly from Cambodia, Laos and Myanmar, only about 500,000 of them documented.¹¹ Often undocumented migrants cannot go to hospitals for treatment as they fear deportation. In many SEA countries there is mandatory HIV testing for migrant workers. If found positive, they are deported. Says Rex

At the same time migration provides significant monetary gains to the migrants' home countries. There are five million overseas Filipino workers, for instance, providing US\$8 billion to the Philippines annually. Indonesian women are among the 140,000 domestic servants working in Singaporean households, or about a third of the estimated 500,000 Indonesians working overseas, who contribute some 2.2 billion in crucial foreign exchange to this country.¹³

Still at their destinations migrant workers are often at the mercy of the employers who can hire and fire at will. In Singapore,



Medical students and health activists at a demonstration in Manila

a manual for employers stipulates norms: " ... good behaviour is expected – that the maid will not get married to a Singaporean; she will not become pregnant while in Singapore, she will not work in a job other than specified in her contract."

There is an urgent need to review the migration and migrant worker policies from a larger human rights perspective. Comments Saruna Verghis, coordinator of Coordination of Action Research on AIDS and Mobility (CARAM) ASIA: "No human being is illegal. Undocumented migration is the production of market economy."

Trading in sex

According to a USAID report, South-East Asia is the greatest source of trafficked women and girls into the United States.¹⁴ Within the region there is flourishing cross-border and internal trafficking.

In the Philippines, there are an estimated 300,000 women and 75,000 children in the sex trade. In Malaysia, there are an estimated 142,000 women in prostitution, 8,000–10,000 of them based in Kuala Lumpur. In Indonesia there were 65,582 registered prostitutes

in 1994. The estimated financial turnover of the sex industry ranges from US\$ 1.2 billion to US\$3.6 billion.¹⁵ One Burmese girl, aged 11, told CNN recently that her father sold her to a Bangkok bar as a sex worker. This bar had a lot of children working there, she said. "My mother thought I was going to school...I can't remember how many customers."¹⁶

Sex trade has serious implications to the HIV spread. Cambodia has a prevalence rate of up to 38 per cent among female sex workers, Myanmar 38.0 per cent. The case of Thailand indicates that HIV prevalence peaked among female sex workers and their clients around the mid 1990s.¹⁷

It may be noted that entertainment sector is a major employment provider in Cambodia and the Philippines. The concern is that unscrupulous elements may abuse the sector. In many South-East Asian countries sex work is still criminalised and the workers have to face violence by both the state and the customers who question their legal legitimacy. Sex workers as a group are vulnerable to HIV and arrested, detained and deported as in the case of Thailand. Reports suggest economic and so-

cial forces driving the sex industry grow stronger, when unemployment is increasing in the region.

Right to quality health service

Most of the South-East Asian governments still have failed to respond to the HIV/AIDS issue from a broader socio-economic, development and human rights perspective. "HIV/AIDS is a development issue and predominantly a socio-economic issue. However many countries in the region have been tackling HIV/AIDS as only a health problem," says Lee Nah Hsu. Worse still, health is not even a priority to many governments. The Fifth ASEAN Ministers Meeting on Healthy ASEAN 2020 declared: "We envision by 2020 that health shall be at the centre of development and ASEAN cooperation in health shall be strengthened to ensure that our people are healthy in mind and body and living in harmony in safe environments." Ironically the member states have failed to provide proper care and support to people living with HIV/AIDS, and give them affordable treatment facilities.

"In our long-standing campaign to get the government to include AIDS drugs in its low cost Public Health Insurance scheme, we realized that ...we had to find a way to lower the cost of this medication. Says prominent AIDS activist, and director of Access, Nimit Thien-udom, "The fact that the patents of many drugs are all held by big drug multinationals made us actively seek a way to deal with the whole TRIPS and patent law issue. Medications should be excluded from international trade pacts."

Care, support and treatment facilities for HIV are often inadequate in the region. With a few

exceptions like Thailand, where people have easy access to health care. In Indonesia ARV drugs cost on average, US\$1000 per person a year whereas the workers' basic annual salaries range from US\$850 to US\$1500.¹⁸ Elizabeth Pisani of Family Health International Indonesia, points out: "Money is not the only issue, and you can't do anything with money unless you have vision, commitment and willingness to work, let's be hopeful, realisations are being made".

The same situation exists in Laos, Myanmar and Cambodia where public health care systems are weak. "Even a rich country like Malaysia with good health infrastructure lacks HIV/AIDS counselling facilities in health care centres," says Angileana Ackermans of UNAIDS, Malaysia. In some parts of Malaysia, mandatory HIV testing was said to be in place, which has stopped of late. Nik Fahmee, Executive Director of Malaysian AIDS Council points out: "Malaysian AIDS council protests all forms of mandatory HIV testing, including mandatory testing for drug users."

In Cambodia, there is low utilisation of voluntary counselling and testing. Poverty in Cambodia fuels the HIV/AIDS epidemic. According to the World Bank, 36 per cent of the people here live below the poverty line, while 18 per cent live below the food poverty line. The rural population accounts for almost 90 per cent of the total number of poor people.

The newly independent Timor-Leste (East Timor) offers a challenging scenario. There is a high incidence of diseases, particularly TB, Malaria, dengue and Japanese encephalitis, which are endemic. For every 1000 births there are 125 deaths and the maternal mortality rate is 890 per 100,000 births. The

health system is inadequately staffed to cope with these problems – let alone the challenge of HIV/AIDS. There are less than 24 Timorese doctors in East Timor.¹⁹ However political commitment seems very strong, indicating a positive sign for the future. Health is second priority (after education) in the country.

The public health care system in Myanmar is going through a critical phase. WHO has noted that Myanmar has the second worst health care system out of the 191 UN member states. There are more private hospitals than public hospitals in the Philippines. Of the 1708 hospitals in the country, 1068 are privately owned and only 640 are public hospitals. Of the 781 billion peso national budget for 2002, only two per cent, or 14.5 billion pesos, was allocated for health services.²⁰

Help from religious leaders

The contribution of religious groups in the region, for example, Islamic response in Indonesia,²¹ Buddhist response in Cambodia, Myanmar, Thailand, Vietnam and, Laos are some of the examples of how religion can contribute in care

and support for people living with HIV/AIDS.²² Various attempts are being made to encourage the religious leaders who really can make a difference in the social psyche. One of such best practices is designed in the context of Malaysia. Ackermans says: "The project involves Islamic religious leaders to enhance awareness, combat the spread of the HIV virus and improve care and support for those infected and/or affected by the HIV virus."

Tarmizi Taher, former Indonesian Minister of Religion is calling for the country's two major Muslim organisations to initiate dialogue about the need for condoms and clean needle use. "You have to use right sentences to persuade people," says Taher. "We call it an emergency, because under Islamic law, if there is an emergency you can change the rules," says Taher. In fact, there is a strong need to respond to the epidemic from an emergency point of view."²³

Influential individuals like Marina Mahathir, daughter of former Malaysian prime minister Mahathir Mohamad, also attempt similar moves. Marina, president of Malaysian AIDS Council, points out:



Health activists call for keeping "WTO out of health" Manila – Nov. 2003

"They are leaders in thought in [the sense that they can influence] how people think and, of course, this affects the idea of women, the idea of marginalised groups, of stigma." On the other hand she has been more vocal against some of the more extreme pronouncements from religious leaders. "And I've got a lot of flak for that," she says.

Cambodia's movement of care and support led by Buddhist monks is another example. Says Tieng Vutho, vice-chief of Monks, of Sray Propei Pagoda: "The pagodas should educate people to love life and to take care of their health so they can enjoy life...In every workshop I have attended, the other pagodas also raise the issue of HIV/AIDS." Tieng Vutho is also a counsellor to people living with HIV/AIDS for the Sray Proper Pagoda, a training centre for monks in Phnom Penh, Cambodia. Their main services include healing through meditation and workshops and advocacy. They also provide food support for families with people living with HIV/AIDS.

Voices make a difference

Though various state and non-state stakeholders are addressing HIV/AIDS in the region, there is a need to collectively translate their commitment into action. There is a need to adopt a human rights framework to address the issue. In countries like Vietnam and Laos independent groups of positive people have yet to find a voice and in other areas there is a strong need to strengthen existing groups. Notes Kamol Uppakaew, chairman of the Thai Network of People Living with HIV/AIDS (TPN+): "In its five years of existence the TPN+ totals 589 groups across the country – group numbers vary from 60 to 100 members. TPN+ and its al-



Trade at a port in 'Golden Triangle'

lies have campaigned for expanded and improved treatment access and related services, leading in some cases to significant victories."

A good outcome of such activism is the Comprehensive Continuum of Care Centres (CCCC), facilitated by the Thai Health Ministry and the Global Fund. CCCC is a concept of community-based care. Medical, psychological, social and nursing support is provided to people with HIV/AIDS and their families by trained medical staff. A growing need for treatment and care has to be addressed in the region.

Lessons

Civil society has started discussion on HIV/AIDS at a time when the whole issue has become medicalised. Civil society has the responsibility to make it a common social issue rather than a medical crisis. Such interventions can help secure the rights of people with HIV/AIDS.

There is need to have better laws in place, respecting the human rights and civil rights of all people, especially the most vulnerable people like the poor, migrants and people with HIV/AIDS. The Philippines and Cambodian laws can be good models for other countries to follow.

Sex industry is growing fast owing to socio-economic reasons and policy neglect. Cambodia, Laos

and Vietnam, for instance, do not have the capacity to deal with the fallout of opening up their tourism industry. Girls and boys from most vulnerable and poorer families form bulk of workers in the sex industry, and they have least access to health care services. Rights of the sex workers and other vulnerable groups must be recognised and honoured.

Activists from all countries in the region assert that rights of the people living with HIV/AIDS to affordable quality treatment should be upheld despite trade compulsions brought about by TRIPS. Capacity of several countries in the region will be tested in balancing rights of its people and 'rights' of the corporate sector to seek profit.

Serious debate on HIV/AIDS is lacking in several countries in the region. Given the seriousness of the emerging problem, debate to instil a sense of deeper social responsibility toward the vulnerable groups is required.

There is a strong need to develop a system of cooperation among government, NGOs/International NGOs, groups of people living with HIV/AIDS and also there is an immediate need to critically examine the strategy to address HIV/AIDS and the mode of resource allocation.

There is an urgent need to develop and strengthen basic health

care system to respond to the health needs of the people. It would mean arresting the current decline in health system, and enhancing investment and access to basic services to all people. Legislative measures in public health policies need to address HIV/AIDS components.

A positive sign is the rising voices of the migrant workers' movements, sex workers, and people living with HIV/AIDS. National/international players can link up with such movements across the region to enable these vulnerable people to realise their basic right to a dignified life.

Endnotes

1. *Crisis Prevention and Recovery* <http://www.undp.org/bcpr/pubinfo/speeches/13-feb-2003-asean.htm>
2. Based on current budgetary allocation for health sector divided by current population
3. *Science*, Vol 301, 19 September 2003
4. *San Francisco Chronicle*, 04.03.03 Rafael D Frank: CDC News Updates
5. *Burma Faces AIDS explosion*, <http://news.bbc.co.uk/1/hi/worldasia-pacific/1562405.stm>.
6. *Xinhua News Agency* 07.07.2003 CDC News Updates
7. UNAIDS 2001
8. New cases of HIV infection reported this year, <http://app.moh.gov.sg/new/new02.asp?id=1&mid=5060>
9. Canadian HIV/AIDS Policy and Law Review: Volume 8 Nov.1: April 2003

10. HIV/AIDS Policy and Law Review Volume 7, Number 2/3, December 2002
11. ESCAP: HIV/AIDS in the Asia Pacific Region: UN;2003
12. South East Asia HIV and Development Program Brunei, Philippines, Singapore Cluster country Consultation on Migrant worker's HIV Vulnerability Reduction sept 2002
13. *Slaves and Heroes*, Jakarta Post, Aug 27,2003, Inter Press Service, ...<http://www.ipsnews.net/migration/stories/briefs2.html>
14. *Trafficking in Persons: USAID Response: USAID women in Development Publications*, 2001
15. CATW: The Fact Book on Global Sexual Exploitation: Southeast Asia/Pacific
16. http://www.cgi.cnn.com/WORLD/9510/thai_prostitutes/
17. HIV/AIDS in Asia and Pacific Region 201
18. Partnership Manu, Joint UN Program on HIV/AIDS, 2002
19. HIV in East More Crisis – HIV Australia Magazine vol.2 no.2Nov/Dec 20.<http://bairopiteclinic.tripod.com/hiv.htm>
20. HIV/AIDS Country Profile Philippines 2002, HAIN
21. EASCAP: HIV/AIDS Prevention, Care and supports from the community: UN/AUS AID
22. The Buddhist Leadership Initiative: UNICEF
23. http://www.thebody.com/cdc/news_updates_archive/2003/jun26_03/indonesia_aids.html

References

IFRC (2002), International Federation of Red Cross and Red Crescent Societies 10.30.2002. <http://www.reliefweb.int/library/documents/2003/ifrc/ifrc-sea-7may.pdf>)
 World Press (2002), *World Press Review*. 25 Nov. 2002. Inter view with

Marina Mahathir. <http://www.worldpress.org/Asia/824.cfm>
 WHO (2001), *HIV/AIDS in Asia and Pacific Region*
 MBCMR (2000), *Impact of the Asia Financial Crisis on Health*, Macfarlane Burnet Centre for Medical Research: http://www.ausaid.gov.au/publications/pdf/health_exec_sum.pdf
 WHO (2003), *HIV/AIDS in Asia Pacific Region*
 ESCAP (2003), *Economic and Social Progress in Jeopardy: HIV/AIDS in the Asian and Pacific Region*: UN
 ESCAP (2002b), *HIV/AIDS and poverty : the impact of HIV/AIDS in the ESCAP region*, Fifth Asian and Pacific Population Conference: UN
 ESCAP (1999), *Economic and Social Survey of Asian and Pacific 1999*: UN
 Pundarik, Mukhopadhyaya (2002), *Crisis, social sector and income distribution in some South East Asian Countries*, working paper 161.(<http://www.hss.se/eijs>, 21 March 2003)
 Pitayanon, S., S. Kongsin and W.S. Janjareon (1997). The Economic impact of HIV/AIDS mortality on house holds in Thailand, in D. Bloom and P. Godwin, eds., *The Economics of HIV and AIDS The Case of South and South East Asia*, Delhi, OUP.)
 UNAIDS (2002), *National and International Financing of The Response to HIV/AIDS in Vietnam*, Hanoi
 ILO (1998), News release: Release simultaneously in Geneva and Manila
 NAA (2003), *Cambodian Report on Follow up to the Declaration of Commitment on HIV/AIDS*, 2003, April
 ADB (2003), *Developing Asia Sub Regional Trends and Prospects*. http://www.adb.org/Documents/Books/ADO/2003/part1_1-d.asp
 ESCAP (2003), *Economic and Social Progress in Jeopardy: HIV/AIDS in the Asian and Pacific Region*, UN
 ActionAid Asia - Cambodia (2003), Pem F Catalla, *Fighting a Different Battle: Cambodia against HIV/AIDS*

VISION

A World without AIDS in which every person can exercise and realise his/her right to a life of dignity.

MISSION

Our Mission is to work with poor and marginalised communities to control vulnerability, achieve sustained improvements in the quality of life and for the realisation of rights in the face of HIV/AIDS, by working through local, national and international partnerships.

ActionAid has been a pioneer in responding to the AIDS epidemic since 1987, when it supported the formation of TASO (The AIDS Support Organisation) in Uganda. Since then AA has developed a strong record in both community-based work and national and international advocacy.

The overarching framework of ActionAid's HIV/AIDS work is human rights with an emphasis on fighting poverty. AA is guided primarily by the long-term interests of poor people, and the values of transparency, participation and ownership. AA strongly believes that people living with HIV/AIDS are key players in the fight against AIDS and must be centrally involved in all levels of the response, including development, implementation and evaluation.

GOALS

The goals of ActionAid's HIV/AIDS work are to contribute as significant actors through programme, policy and campaigning to ensure the following:

- **Resources:** A massive sustained increase in resources allocated to fight HIV/AIDS at all levels, with priority given to countries and people that are hardest hit and most vulnerable.
- **Leadership:** Strong, accountable leadership and political commitment to consistent, effective and open action against HIV/AIDS.
- **Human rights:** The recognition, fulfilment and protection of the rights and roles of people infected, affected and vulnerable to HIV/AIDS.
- **Fighting poverty:** A mainstreamed HIV/AIDS response in the fight against poverty that addresses the special needs and demands created by the epidemic.
- **Essential health and social care:** Access to HIV/AIDS prevention, care, treatment and support that safeguard the rights of poor and marginalised people.
- **Monitoring and accountability:** Effective surveillance, monitoring, evaluation and accountability systems
- **Alliance and movement building:** Strategic participation in and collaboration to strengthen movements of infected, affected and vulnerable communities
- **Scaled-up community response:** Expanded and intensified community-driven responses to HIV/AIDS that minimise further impoverishment and improve quality of life.

WORK

Drawbacks of mainstream approaches – how ActionAid is different

The all too common 'ABC' approach to HIV and AIDS consists of instructing people to Abstain, Be Faithful and Use Condoms. Usually this is accompanied by vigorous dissemination of information about how HIV is transmitted and how it can be prevented, on the false assumption that information leads automatically to behaviour change. Of course, access to information and to sexual health commodities such as condoms is important. The mistake is to assume that they are sufficient on their own to bring about change.

Perhaps the most fundamental miscalculation of mainstream approaches has been their failure to address gender inequity. Most women in the world have no choice over when, whether or in what circumstances to have sex. What good is a condom or knowledge of risk to a woman who has no right to say no? Far from empowering her, possessing such information or commodities may only make her even more vulnerable to suspicion and abuse. Unless gender equity is explicitly addressed, we cannot hope to tackle HIV and AIDS effectively.

It was from ActionAid's recognition of the drawbacks of the 'ABC' and 'information = behaviour change' recipes that its combination of innovative interventions was born.

Examples of key ActionAid interventions to date

- **Strategies for Hope series:** An influential series of booklets and videos documenting successful community-led responses to the epidemic, designed to inform and inspire others.
- **Strategies for Action:** The umbrella term for ActionAid's approach of strengthening community-based organisations to provide effective prevention, care, treatment and advocacy.
- **Stepping Stones:** Participatory method that works at community level to improve open communication, increase gender equity and empower women and men, young and old, to protect their sexual health. Developed by ActionAid in 1995 and now used in over 100 countries, most recently in Latin America and the Caribbean.
- **SIPAA (Support to the International Partnership against AIDS in Africa):** Building bridges between civil society and governments to ensure effective national responses to the epidemic in Ethiopia, Rwanda, Burundi and Ghana, along with a regional component to share learning and best practice.
- **Global Fund campaign:** Based in Italy, Spain and the UK, a campaign to put pressure on EU governments to contribute their fair shares to the Global Fund for AIDS, TB and Malaria.
- **Access to treatment campaign:** Fighting to bring treatment within the reach of ordinary people. In Kenya last year, ActionAid and Médecins Sans Frontières imported US\$10,000 worth of generic antiretroviral drugs (ARVs) from India and distributed them through Kenya's Christian hospitals network. The immediate effect was a drop in the price of ARVs from 7,000 Kenyan shillings a month to 3,000, as pharmaceutical companies dropped the prices of their patented drugs in order to compete.
- **Building local advocacy skills:** Supporting positive people's groups to come together and demand their rights to health care from government.
- **Mainstreaming within emergency response:** Addressing the HIV/AIDS aspects of the food security crisis in Mozambique and other parts of southern Africa. For example, people living with HIV/AIDS need food at the right times and of the right nutritional value for them to be able to take some of the drugs prescribed to them.

CHALLENGE

The biggest challenge at all levels remains the mutual reinforcement of HIV/AIDS and poverty. AA has to address this challenge throughout its work to achieve its mission.

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**ActionAid is a unique partnership of people fighting for a better world –
a world without poverty.**

Time to Act is about one of the greatest humanitarian crises of all times – HIV/AIDS. Two decades after it began its onslaught in sub-Saharan Africa, the disease has gained a firm foothold in Asia, threatening millions of lives in some of the world's most populous nations.

It is a snowballing crisis. UNAIDS notes that Asia and the Pacific region have an estimated 7.2 million people living with the virus. Almost a million people here acquired HIV in 2002. It is a challenge for humanity.

HIV/AIDS targets the poor, and thrives under conditions of conflict, displacement and weak public health and social safety systems – banes of many Asian countries. A growing trend of placing profits above people worsens the crisis.

ActionAid is committed to listen and learn from our own experience in Africa and from others. *Time to Act*, we hope, will serve as a 'reality check' for future interventions in Asia.

We see HIV/AIDS as an issue that warrants an emergency humanitarian response as well as a human rights and development intervention.

ActionAid is a unique partnership of people fighting for a better world – a world without poverty. As one of the largest development agencies, ActionAid works in more than 40 countries in Africa, Asia, Latin America and the Caribbean, listening to, learning from and working in partnership with over nine million of the world's poorest people.

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The question is no longer whether Asia will have a major epidemic, but rather how massive it will be.

– Dr PETER PIOT, Executive Director, UNAIDS

The political leadership looks at HIV/AIDS as one of the biggest threats to development. We want to prevent the disease before it threatens the existence of the people.

– Dr RUI MARIA DE ARAUJO, Health Minister, Timor-Leste (East Timor)

It (HIV/AIDS) is attaining a more political nature.

– SATUR C OCAMPO, President Bayan Muna (People First), Philippines

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